ANALYSIS OF AGREEMENT CONTAINING CONSENT ORDERS TO AID PUBLIC COMMENT

In the Matter of UnitedHealth Group Incorporated, Collaborative Care Holdings, LLC, DaVita Inc., and DaVita Medical Holdings, LLC, File No. 181-0057

I. INTRODUCTION AND BACKGROUND

The Federal Trade Commission ("Commission") has accepted, subject to final approval, an Agreement Containing Consent Orders ("Consent Agreement") from UnitedHealth Group Incorporated ("UnitedHealth Group"), Collaborative Care Holdings, LLC, DaVita Inc. ("DaVita") and DaVita Medical Holdings, LLC (collectively, "Respondents") to remedy the anticompetitive effects that otherwise would result from UnitedHealth Group's acquisition of DaVita Medical Group ("DMG") (the "Proposed Acquisition") in Clark and Nye Counties, Nevada (the "Las Vegas Area"). The proposed Consent Agreement, among other things, requires UnitedHealth Group to divest DMG assets related to the Healthcare Partners of Nevada ("HCPNV") business to IHC Health Services, Inc. ("Intermountain Healthcare") or another buyer approved by the Commission.

On December 5, 2017, UnitedHealth Group entered into an equity purchase agreement to acquire DaVita's DMG division. The Proposed Acquisition would combine the two largest managed care provider organizations ("MCPOs") in the Las Vegas Area. The Proposed Acquisition would also combine DMG's MCPO with the largest Medicare Advantage insurer in the Las Vegas Area. On June 17, 2019, by a vote of 4-0-1, the Commission issued an administrative complaint alleging that the Proposed Acquisition, if consummated, would violate Section 7 of the Clayton Act, as amended, 15 U.S.C. § 18, and Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 45, by (i) removing an actual, direct, and substantial competitor from the Las Vegas Area for MCPO services sold to Medicare Advantage health plans ("MA plans") and (ii) lessening competition in the market for MA plans sold to individuals. The proposed Consent Agreement would remedy the alleged violations by requiring a complete divestiture of DMG's HCPNV assets relating to the HealthCare Partners Nevada business ("HCPNV Assets") and granting certain related licenses. This divestiture will replace the competition that otherwise would be lost in the Las Vegas Area because of the Proposed Acquisition.

The proposed Consent Agreement has been placed on the public record for 30 days to solicit comments from interested persons. Comments received during this period will become part of the public record. After 30 days, the Commission will review the comments received and decide whether it should withdraw, modify, or make the Consent Agreement final.

II. THE PARTIES

UnitedHealth Group is a for-profit healthcare company headquartered in Minnetonka, Minnesota. UnitedHealth Group is comprised of two business entities: (1) UnitedHealthcare ("United"), which operates as United's health insurance branch; and (2) Optum, which operates as its health services unit. Within Optum is the OptumCare business segment, which includes employed medical groups, independent physicians associations ("IPAs") or affiliated physician networks, ambulatory surgical centers, and urgent care centers. In 2018, United had revenues of $226.2 billion.

DaVita is the parent company to DMG and DaVita Kidney Care, its dialysis division. Headquartered in Denver, Colorado, DaVita had revenues of $11.4 billion in 2018. DMG operates medical groups and affiliated physician networks across six states: California, Colorado, Florida, Nevada, New Mexico, and Washington.

III. THE PRODUCTS AND THE STRUCTURE OF THE MARKET

A. Industry Overview

Individuals age 65 or over are eligible for Medicare, through which the federal government provides health insurance benefits to seniors. The provision of health insurance to Medicare-eligible beneficiaries is administered through two programs: (1) government-provided Medicare ("Original Medicare"), and (2) privately-provided MA plans funded by the federal government. Under Original Medicare, a beneficiary receives inpatient acute care coverage under Medicare Part A and coverage for physician and outpatient services under Medicare Part B, and the federal government reimburses healthcare providers according to a fee schedule determined by the Centers for Medicare and Medicaid Services ("CMS"). Original Medicare enrollees may obtain care from any healthcare provider that accepts Original Medicare rates.

Rather than enroll in Original Medicare, a senior may choose to enroll in an MA plan sold by a private insurer. Under the Medicare Advantage ("MA") program, the federal government pays private insurers to provide health insurance to Medicare-eligible seniors. Participating insurers, known as Medicare Advantage Organizations ("MAOs"), enter into contracts with CMS, pursuant to which they are permitted to offer MA plans to seniors. Many MA plans also offer vision, dental, hearing, or fitness benefits that are unavailable through Original Medicare.

The amount the federal government pays an MAO for each enrollee is determined by an annual bid process overseen by CMS. To be successful, MAOs need to deliver care at a cost that is below the payments they receive from CMS (plus any additional premiums they charge to enrollees). Accordingly, MAOs control costs by proactively managing the health of their enrollees to reduce the amount of healthcare services required by their enrollees.

Like commercial health insurance plans sold to the under-65 population, MA plans feature negotiations between MAOs and providers, provider networks, and plan designs that

incentivize members to seek care from in-network providers. In order to align providers' financial incentives with their own, MAOs have implemented a number of different reimbursement models in their contracts with providers, and these models vary in the way "risk" is distributed between insurers and providers. In healthcare, "risk" refers to financial liability for unexpected medical expenditures. While some proportion of healthcare spending is predictable (e.g., preventive care), a large proportion of healthcare spending goes to high-cost, low-probability events that are unexpected (e.g., an emergency hospital admission or non-elective surgery). In some cases, those provider relationships are centered on risk-based contracts, which pay providers according to various measures of care quality, outcomes, or the ability to control healthcare costs rather than the volume of services they provide. When these cost control measures are successful, MAOs may funnel the savings back into their MA plans in the form of reduced out-of-pocket costs or additional benefits for members.

B. Relevant Product Markets

The Proposed Acquisition poses substantial antitrust concerns in two relevant product markets. First, the horizontal consolidation of the Optum and DMG MCPOs raises concerns in the market for the sale of MCPO services to MAOs and their members. Second, the vertical integration of DMG's MCPO and United's MAO business raises competition concerns in the market for MA plans sold to individuals.

1. MCPO Services Sold to MAOs

One relevant service market in which to analyze the effects of the Proposed Acquisition is the sale of MCPO services to MAOs. An MAO's provider network—and its primary care physicians in particular—is critical to the success of the MAO. The most successful MAOs utilize networks of providers willing to work closely together to coordinate patient care and control healthcare costs. MCPOs are collaborative organizations of such healthcare providers. To varying degrees, MCPOs orchestrate networks of owned, employed, and affiliated providers—including hospitals, outpatient clinics, physician groups, and individual physicians—for the purpose of managing the care of an MA plan's patient population. MCPOs often employ a variety of clinical and non-clinical support personnel (e.g., social workers, nurses, care coordinators, and utilization managers) and have developed information technology systems dedicated to managing care utilization and monitoring patient care.

MCPOs can materially affect the attractiveness of an MA plan to seniors. MA members seek MA plans that offer high quality networks at a competitive price. Without an MCPO's cost control and utilization management functions, an MAO faces a significant chance of increased costs, which can in turn increase MA plan prices and decrease the value of the MA plan's benefits. MCPOs also engage the MAO regularly to address performance issues and improve MA Plan quality scores.

2. Medicare Advantage Health Plans Sold to Individual MA Members

The second relevant product market implicated by this transaction is the sale of MA plans

to individuals. MA plans are meaningfully differentiated from other types of health insurance products, including Original Medicare plans, eligibility-restricted Medicare options (e.g., special needs plans or "SNPs"), employer-group MA plans, and commercial health plans.

Once seniors "age into" Medicare, they may choose between coverage through Original Medicare or MA plans. As noted in *United States v. Aetna Inc.*, 240 F. Supp. 3d 1 (D.D.C. 2017), seniors who choose to enroll in an MA plan overwhelmingly tend to remain in MA plans as opposed to transitioning to Original Medicare. MA plans are differentiated from Original Medicare in several important respects, including MA plans' limited networks, caps on out-of-pocket spending, coordination of care by providers, and members' access to supplemental benefits like prescription drug coverage. *See Aetna*, 240 F. Supp. 3d at 26-28, 30, 41. Therefore, the market for individual MA plans excludes Original Medicare. *See Aetna*, 240 F. Supp. 3d at 41.

The market for MA plans also excludes eligibility-restricted Medicare options such as SNPs and employer-group MA plans. SNPs are MA plans specifically designed to provide targeted care and limit enrollment to special needs individuals through specialized benefits and networks designed to treat specific conditions or needs.[1] Unless an individual MA member has or develops a qualifying need, that member cannot enroll in a SNP. Employer-group MA plans are customized for Medicare-eligible retirees of a particular employer. An MA enrollee cannot enroll in an employer-group MA plan unless they are a former employee of a participating employer.

Finally, the market for MA plans also excludes commercial health plans. MA plans often feature zero or very low premiums and are thus much less expensive for individuals compared to commercial health insurance products, which frequently charge much higher premiums. Seniors who purchase MA plans therefore are not likely to purchase a commercial health plan in the event of a price increase on all MA plans.

C. Relevant Geographic Market

The relevant geographic market in which to analyze the effects of the Proposed Acquisition is no broader than the Las Vegas Area. Healthcare markets are local in nature. Evidence gathered from market participants shows that patients—and particularly seniors—strongly prefer to receive care as close to home as possible. Accordingly, MAOs that wish to market MA plans to seniors in the Las Vegas Area must offer MCPOs within the Las Vegas Area in their provider networks (i.e., they cannot substitute MCPOs located outside the Las Vegas Area). Moreover, as a general matter, seniors may only subscribe to MA plans approved for sale in their county of residence. Therefore, a Medicare-eligible senior typically cannot substitute an MA plan approved for another county for an MA plan offered in their county of residence.

[1] https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/index.html. Special needs patients include people who are institutionalized, have dual-eligibility for Medicare and Medicaid, or have a severe or disabling chronic condition specified by CMS.

IV. THE EFFECTS OF THE PROPOSED ACQUISITION

The Proposed Acquisition would likely result in substantial competitive harm to consumers in the two relevant markets. First, the Proposed Acquisition would combine the two leading MCPOs in the Las Vegas Area. Together, the Optum and DMG MCPOs cover more than 80% of MA members in the Las Vegas Area. Accordingly, the Proposed Acquisition would lead to a presumptively anticompetitive increase in market concentration in the MCPO market. This presumption of anticompetitive harm is supported by evidence of the close competition between Optum and DMG that would be eliminated by the Proposed Acquisition. Seniors in the Las Vegas Area benefit from this head-to-head competition in the form of lower health care costs and higher quality of care. If combined, DMG and Optum would gain additional leverage and be able to demand higher reimbursement rates from MAOs, and would have reduced incentives to maintain and improve their quality of care. Ultimately, these effects would be felt by local seniors in the form of higher premiums, co-pays, and out-of-pocket costs, as well as reduced access to high quality care.

The Proposed Acquisition would also likely harm competition in the market for MA plans sold to individuals in the Las Vegas Area by combining DMG's strong position in the MCPO market with United's strong position in the MAO market. The merged firm would have the incentive and ability to negotiate higher reimbursement rates for MCPO services from United's MAO rivals, making those rivals less competitive. This would worsen seniors' options, reduce competition, and ultimately increase prices or reduce quality (e.g., supplemental benefits) in the market for MA plans sold to individuals in the Las Vegas Area.

V. THE PROPOSED CONSENT AGREEMENT

The proposed Consent Agreement remedies the competitive concerns raised by the Proposed Acquisition by requiring UnitedHealth Group to divest the HCPNV Assets and grant related licenses to Intermountain Healthcare or another buyer approved by the Commission. The HCPNV Assets include all assets and rights related to the HCPNV business, including ownership interest in the relevant operating companies, rights under the medical group agreements, real property, governmental approvals, and business information. The proposed Consent Agreement requires the Respondents to provide transition services and allow the use of the HealthCare Partners brand for a period of time to facilitate the transfer of the business. In addition, the proposed Consent Agreement limits UnitedHealth Group and DaVita's use of, and access to, confidential business information pertaining to the divestiture assets.

With the HCPNV Assets and related licenses, Intermountain Healthcare can preserve the competition that currently exists in the two relevant markets. Intermountain Healthcare is a successful, not-for-profit healthcare system consisting of hospitals, clinics, medical groups, and a health plan, SelectHealth. Headquartered in Salt Lake City, Utah, Intermountain Healthcare serves MA patients across the entire continuum of care in Utah and Idaho. Intermountain Healthcare has the experience to ensure the continued use of the HCPNV business such that they remain an effective competitor to United in the Las Vegas Area. Moreover, Intermountain

Healthcare is familiar with the Las Vegas Area through SelectHealth, which began offering an MA plan in Clark County this year. Intermountain Healthcare also has a minority ownership interest in P3 Health Group Holdings LLC, which owns and operates P3 Health Partners, a recent MCPO entrant to the Las Vegas Area. However, contingent on consummation of the proposed divestiture, Intermountain Healthcare has entered into a contract to divest this ownership interest in P3 Health Group Holdings, LLC, and forfeit its associated board seats. SelectHealth's current negligible share of the MA market in the Las Vegas Area and our analysis of Intermountain's and competitors' business incentives following the proposed divestiture indicate that Intermountain's ownership of SelectHealth does not raise concern for overall competition.

United must complete the divestiture within 40 days of closing the Proposed Acquisition. The proposed Consent Agreement provides for the appointment of a monitor to ensure UnitedHealth Group's and DaVita's compliance with the obligations set forth in the Orders. The proposed Consent Agreement requires Respondents to provide transition assistance to facilitate the transfer of the business to the buyer. The proposed Consent Agreement also contains appropriate compliance reporting requirements. If Respondents do not fully comply with the obligation to divest the HCPNV Assets, the Commission may appoint a Divestiture Trustee to divest the HCPNV Assets.

The proposed Consent Agreement contains a prior notice provision for subsequent acquisitions by Respondent UnitedHealth Group of any ownership interest in any healthcare provider in the Las Vegas Area. Under the proposed Consent Agreement, for the next ten years, Respondent UnitedHealth Group will be required to give the Commission 30 days' advanced notice of any such acquisition that is not subject to the Hart-Scott-Rodino Act, and provide a copy to the Attorney General of the State of Nevada. If 30 days expire without Commission action, Respondent UnitedHealth Group may consummate the proposed acquisition. Otherwise, Respondent UnitedHealth Group must produce to the Commission information and documents relating to the proposed acquisition in response to a written request, and not consummate the transaction until 20 days after substantially complying with the Commission's request.

The proposed Decision and Order will have a term of ten years.

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The sole purpose of this analysis is to facilitate public comment on the proposed Consent Agreement. This analysis does not constitute an official interpretation of the proposed Consent Agreement or modify its terms in any way.