WHEN PAST IS *NOT* PROLOGUE: THE WEAKNESS OF THE ECONOMIC EVIDENCE AGAINST HEALTH INSURANCE MERGERS

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WHEN PAST IS *NOT* PROLOGUE: THE WEAKNESS OF THE ECONOMIC EVIDENCE AGAINST HEALTH INSURANCE MERGERS

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Summary

This white paper counsels extreme caution in the use of past statistical studies of the purported effects of health insurance company mergers to infer that today's proposed mergers — between Aetna/Humana and Anthem/Cigna — will likely have similar effects. Focusing on one influential study — *Paying a Premium on Your Premium* (*"Paying a Premium"*) by Dafny, Duggan & Ramanarayanan ("Dafny, *et al.*")[1] — as a jumping off point, we highlight some of the many reasons that past is *not* prologue.[2]

In short: extrapolated, long-term, cumulative, average effects drawn from 17-year-old data may grab headlines, but they really don't tell us much of anything about the likely effects of a particular merger today, or about the effects of increased concentration in any particular product or geographic market.

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[1] Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, *Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry*, 102 AM. ECON. REV. 1161 (2012) [hereinafter "*Paying a Premium*"].

[2] *Cf. Health Insurance Industry Consolidation: Hearing Before the Subcomm. on Antitrust, Competition Policy, and Consumer Rights of the S. Comm. of the S. Comm. on the Judiciary*, 114th Cong. (Sept. 22, 2015) (statement of Leemore S. Dafny, Ph.D.), *available at* https://www.judiciary.senate.gov/download/09-22-15-dafny-testimony-updated at 9 [hereinafter "Dafny Testimony"].

Introduction

On July 21, the Department of Justice (DOJ) announced that it had sued to block both the Aetna-Humana and Anthem-Cigna mergers.[3] In their press conference, Attorney General Loretta Lynch and Associate Attorney General Bill Baer argued that the mergers would lead to less competition and higher premiums for health insurance consumers.[4]

The DOJ's complaints rely heavily upon a (largely discredited) structural presumption that a loss of one head to head competitor will lead to higher premiums and harm to consumers.[5] This is not new.

In the lead–up to the government's decision to challenge the mergers, Congress held several hearings on the health insurance marketplace — paying particular attention to the pending merger of four of the nation's top five "national" health insurance providers: Aetna/Humana and Anthem/Cigna.[6]

At those hearings and elsewhere, numerous voices, including, among others, the American Antitrust Institute (AAI),[7] the Center for American Progress (CAP),[8] the

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[3] *See* Complaint, United States of America, *et al*. v. Aetna Inc. and Humana Inc., Case 1:16-cv-01494 (Jul. 21, 2016), *available at* https://www.justice.gov/opa/file/877881/download; Complaint, United States of America, *et al*. v. Anthem Inc. and Cigna Corp., Case 1:16-cv-01493 (Jul. 21, 2016), *available at* https://www.justice.gov/opa/file/877886/download.

[4] *See* Attorney General Loretta E. Lynch Delivers Remarks a Press Conference Announcing the Justice Department's Actions to Block Aetna's Acquisition of Humana and Anthem's Acquisition of Cigna (Jul. 21, 2016), *available at* https://www.justice.gov/opa/speech/attorney-general-loretta-e-lynch-delivers-remarks-press-conference-announcing-justice.

[5] *See* Complaints, *supra* note 3.

[6] *See Healthy Competition? An Examination of the Proposed Health Insurance Mergers and the Consequent Impact on Competition: Hearing Before the Subcomm. on Regulatory Reform, Commercial, and Antitrust Law of the H. Comm. on the Judiciary*, 114th Cong. (Sept. 29, 2015); *Health Insurance Industry Consolidation: Hearing Before the Subcomm. on Antitrust, Competition Policy, and Consumer Rights of the S. Comm. of the S. Comm. on the Judiciary*, 114th Cong. (Sept. 22, 2015).

[7] American Antitrust Institute, *Letter to Bill Baer Re: Antitrust Review of the Aetna-Humana and Anthem-Cigna Mergers* (Jan. 11, 2016), *available at* http://www.antitrustinstitute.org/sites/default/files/Health%20Insurance%20Ltr_1.11.16.pdf.

[8] Topher Spiro, Muara Caslyn, & Meghan O'Toole, *Bigger Is Not Better: Proposed Insurer Mergers Are Likely to Harm Consumers and Taxpayers*, CENTER FOR AMERICAN PROGRESS (Jan. 21, 2016), *available at* https://cdn.americanprogress.org/wp-content/uploads/2016/01/20122028/InsuranceMergers-brief3.pdf.

Commonwealth Foundation,[9] and the American Medical Association (AMA),[10] contributed to a growing chorus arguing that competition agencies should reject outright the proposed mergers. Critics focused on the level of concentration already present in the health insurance marketplace and presume, essentially, that any increase in concentration will cause harm.

A wide range of powerful critics, including prominently among them Senator Blumenthal, base their opposition to the proposed mergers largely on a small set of papers purporting to demonstrate that an increase of premiums, without corresponding benefit, inexorably follows health insurance "consolidation."[11]

Virtually all of the casual claims that health insurance mergers will harm either healthcare providers or consumers (or both) are based on a case study of a 1999 merger by economist Leemore Dafny, *et al.*,[12] as well as associated testimony by Dafny,[13] along with a few empirical and theoretical papers by her and others.[14] But

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[9] Leemore S. Dafny, *Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience*, 33 COMMONWEALTH FUND 1 (Nov. 2015), *available at* http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/nov/1845_dafny_impact_hlt_ins_industry_consolidation_ib.pdf.

[10] *AMA Releases Analyses on Potential Anthem-Cigna and Aetna-Humana Mergers*, AMERICAN MEDICAL ASSOCIATION (Sept. 8, 2015), *available at* http://www.ama-assn.org/ama/pub/news/news/2015/2015-09-08-analysis-anthem-cigna-aetna-humana-mergers.page.

[11] *Blumenthal Reiterates Call for Intense Scrutiny of Health Insurance Mergers at Senate Judiciary Committee Hearing*, (Sept. 22, 2015), *available at* http://www.blumenthal.senate.gov/newsroom/press/release/blumenthal-reiterates-call-for-intense-scrutiny-of-health-insurance-mergers-at-senate-judiciary-committee-hearing ("I'm deeply troubled by the evidence that shows that neither providers nor consumers benefit from these mergers … the Prudential-Aetna experience shows that premiums are not lowered, that consumers do not benefit, and that the savings are not passed along to consumers."). While the merger trials themselves will turn on expert economic analysis created specifically for the trials, it appears that the government's expert may rely on a model using an analogous extrapolation to that of *Paying a Premium*. *See* Defendants' Pre-Trial Brief, United States of America v. Aetna Inc and Humana Inc, Case 1:16-cv-01494-JDB (D.D.C Nov. 23, 2016) at 16 ("The Government's expert, Dr. Aviv Nevo,… relies on a diversion ratio derived from one economic model multiplied by implied margins derived from another, [and] fails to account for actual market facts….").

[12] *Paying a Premium*, *supra* note 1.

[13] Dafny Testimony, *supra* note 2.

[14] *See, e.g.*, Erin E. Trish & Bradley J. Herring, *How do health insurer market concentration and bargaining power with hospitals affect health insurance premiums?*, 42 J. HEALTH ECON. 104 (2015); Leemore S. Dafny, *Are Health Insurance Markets Competitive*, 100 AM. ECON. REV. 1399 (2010); Jose R. Guardado, David W. Emmons, & Carol K. Kane, *The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra*, 1 HEALTH MGMT. POL. & INNOVATION No, 3, 2013, at 16-35.

a closer analysis of their claims shows that the case against health insurance mergers in the current marketplace, and especially given the current regulatory environment, isn't supported by such evidence. And while we don't know what the DOJ's analysis will look like at trial, or what data they have relied upon, they will have to do better than these studies have at connecting the mergers to anticompetitive results in the markets at hand.

Below, we offer an assessment of Dafny, *et al.*'s paper, *Paying a Premium on Your Premium* (*"Paying a Premium"*), and question its applicability to the current, proposed health insurance mergers. We also explore some of the general limitations of health insurance competition research, particularly in light of the Affordable Care Act's (ACA) sweeping regulatory changes. It is possible that the proposed mergers would have anticompetitive effects, of course. But the existing evidence cited to *support* that conclusion does not, in fact, do so.

The ACA elephant in the room

First, it must be noted that things have changed considerably since the 1999 merger that forms the core of *Paying a Premium*. What is perhaps most notable, and what truly makes it impossible to draw inferences from statistical results based on the effects of a 17-year-old merger, is that today's proposed mergers, and today's health insurance marketplace, are extremely different.

This is *not* the much-maligned "the government made me do it"[15] argument; rather, it is a recognition that things have changed — *considerably* — and it is impossible to say, as Dafny frequently does, that "past is prologue."[16]

The ACA is no minor tweak to the market. It is a fundamental and comprehensive change in the underlying regulatory environment for health care and health insurance, and it is a certain mistake to draw inferences about competitive conditions in a post-ACA world from analyses undertaken in a pre-ACA one. As one scholar has written (in this case with respect to individual insurance markets),

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[15] *See, e.g.*, Thomas Greaney, *New Health Care Symposium: Dubious Health Care Merger Justifications—The Sumo Wrestler And 'Government Made Me Do It' Defenses*, HEALTH AFFAIRS BLOG (Feb. 24, 2016), http://healthaffairs.org/blog/2016/02/24/dubious-health-care-merger-justifications-the-sumo-wrestler-and-government-made-me-do-it-defenses/.

[16] *See, e.g.,* Dafny Testimony, *supra* note 2, at 9.

"[i]nsurers participating in these exchanges operate under very different rules from traditional health plans…."[17] But that is just the tip of the iceberg.

The reality is that health insurance markets are mind-bogglingly complex[18] — if you need proof look no further than the ACA and its implementing regulations themselves, which (so far) total something like 1,000 pages and 10,000 pages, respectively. While small-scale studies of previous mergers (like *Paying a Premium*) focus on narrow geographic areas or on limited outcome variables (like consumer prices, for example) because these are relatively tractable, they simply cannot account for the complex, wide-ranging and subtle effects that (shifting) regulatory changes in the healthcare market can bring about.

In fact, it is the impending phase-out of a significant part of the ACA's regulatory scheme that may help explain why the mergers are happening now.

The ACA makes it more difficult for insurance companies to manage risk by mandating community rating and by forbidding price discrimination or denial of coverage based on pre-existing conditions. A good deal of the complexity of the law is the result of its own (though limited) recognition of this and its efforts to ameliorate the effect of the ACA's mandates. Thus, the ACA contains provisions to "guarantee" a larger risk pool to offset the difficulties associated with covering all patients regardless of risk through the health insurance marketplace and the imposition of the individual mandate, for instance. Nevertheless, even if these mechanisms had effectively diversified away increased risk among insurers (which they haven't[19]), insurers still need to deal with substantial residual, increased risk from the new system. And thus the ACA also created the "three Rs" — "reinsurance," "risk corridors," and "risk adjustment" — to provide insurance

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[17] William M. Sage, *Assembled Products: The Key to More Effective Competition and Antitrust Oversight in Health Care*, 101 CORNELL L. REV. 609, 653 n.208 (2016).

[18] *See* Geoffrey Manne & Ben Sperry, *The competitive implications of the Affordable Care Act for health insurance merger review*, TRUTH ON THE MARKET (Oct. 5, 2015), https://truthonthemarket.com/2015/10/05/the-competitive-implications-of-the-affordable-care-act-for-health-insurance-merger-review/.

[19] *See, e.g.*, Brian Blase, *New Data Shows Large Insurer Losses on Obamacare Plans*, FORBES (Oct. 12, 2015), http://www.forbes.com/sites/theapothecary/2015/10/12/new-data-shows-large-insurer-losses-on-obamacare-plans/#6a11df2d4bb3. (Despite administration claims that incoming payments from profitable insurers would cover losses from unprofitable ones, the risk corridor program shortfall exceeded $2.5 billion in 2014. Insurers with lower-than-anticipated claims owed about $360 million, and insurers with higher-than-anticipated claims requested about $2.9 billion from the program.).

companies some (extremely limited) insulation from the possibly jarring and significant increase in risk.

Reinsurance is a temporary program designed to be a stop-gap for insurance companies that were unable to accurately estimate the risk associated with new signees — leading to drastic rises in the years immediately following implementation.[20] When an enrollee in an ACA-compliant, non-grandfathered plan consumes $45,000 or more in medical expenses, that plan qualifies as "high risk" and triggers reinsurance payments to the carrier. This temporary program (which has been phasing out since its inception and is set to expire this year) is funded by fees imposed on all insurance plans (except for plans that are both self-funded and self-administered).

Similarly, risk corridors redistribute profits and losses for qualified individual and small group insurance plans between insurers and the federal government according to a formula administered by HHS. This program (which also phases out at the end of 2016) involves calculating the ratio of allowable costs to the target cost with a small allowance for administrative costs. Notably, this method of calculating risk corridor payments doesn't correspond to actual profit and loss.

Finally, risk adjustment is a permanent program that mandates that insurance companies that take on lower than average risk (again, for individual and small group plans) within each market compensate those insurers that take on higher than average risk. The risk adjustment transfer payments apply to all plans within a state, ACA-compliant and non-ACA compliant, and are thus designed to diversify risk among all insurers in a state.

It is likely no coincidence that the major insurance companies, several of which are losing a lot of money in the individual insurance marketplaces due to sicker-than-expected enrollees, are looking to cut costs and consolidate (in part to engage in their own risk diversification) as those risk mitigation provisions are phased out. Whatever their other merits, challenges to (or conditions placed upon) those efforts at consolidation based on evidence amassed from situations with very different regulatory environments, especially regarding risk, are likely to have problematic consequences in the current environment.

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[20] *See, e.g.*, Robert Pear, *Health Insurance Companies Seek Big Rate Increases for 2016*, NEW YORK TIMES (Jul. 3, 2015), http://www.nytimes.com/2015/07/04/us/health-insurance-companies-seek-big-rate-increases-for-2016.html.

Aetna, for instance, was apparently hoping to use its merger with Humana to expand its footprint in the public (ACA) individual marketplace, but has since decided to restrict its participation in the exchanges due to the economic losses it has already incurred, and may exit the public exchanges altogether if the merger is blocked.[21] Aetna is not alone in losing tremendous amounts of money on the public individual exchanges, and UnitedHealthcare, for example, has announced plans to exit these marketplaces as well.[22] The alternative, which has been pursued in many states, has been to raise the premiums to make up for losses.[23] That process, and its interaction with plans in other markets, has been quite telling. As one article recounts:

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[21] *See* Letter from Aetna to Ryan M. Kantor, Department of Justice Antitrust Division (Jul. 5, 2016), *available at* http://big.assets.huffingtonpost.com/AetnaDOJletter.pdf. *See also* Bob Bryan, *Aetna, one of the country's largest health insurers, is ditching 70% of its Obamacare business*, Business Insider (Aug. 15, 2016), *available at* http://www.businessinsider.com/aetna-ditching-70-of-obamacare-business-2016-8. *See also* Defendants' Pre-Trial Brief, *supra* note 11, at 5:

> It is beyond dispute that Defendants no longer compete with one another in any of the counties challenged in the Complaint. That is because Aetna (which had incurred more than $200 million in exchange-related losses from the inception of the exchanges through the end of 2015; received and reviewed substantial risk-adjustment and claims data in late June and early July indicating that conditions on the exchanges were worse than expected; and, on the basis of that data, projected $300 million in additional exchange-related losses this year) decided to withdraw from ACA exchanges in more than 500 counties, including the 17 counties in the Complaint, effective January 1, 2017. Accordingly, the Government bears the burden of proving that Aetna would re-enter the exchanges in the short-term but for the merger—a highly speculative (and even less likely) proposition given Aetna's exchange-related losses and its inability to recoup them in light of the ACA's structural flaws.

[22] *See* Carolyn Y. Johnson, *UnitedHealthcare Group to exit Obamacare exchanges in all but a 'handful' of states*, Washington Post (Apr. 19, 2016), *available at* https://www.washingtonpost.com/news/wonk/wp/2016/04/19/unitedhealth-group-to-exit-obamacare-exchanges-in-all-but-a-handful-of-states/.

[23] *See, e.g.*, Robert Pear, *Why Do Health Costs Keep Rising? These People Know*, THE NEW YORK TIMES (Jun. 9, 2016), http://www.nytimes.com/2016/06/10/us/health-insurance-affordable-care-act.html; JoNel Aleccia, *Rate requests way up for 2017 individual health-care plans*, THE SEATTLE TIMES (May 16, 2016), http://www.seattletimes.com/seattle-news/health/rates-going-way-up-in-2017-for-individual-health-care-plans/; Louise Radnofsky & Stephanie Armour, *Insurers Win Big Health Rate Increases*, WALL ST. J. (Aug. 27, 2015), http://www.wsj.com/articles/insurers-win-big-health-rate-increases-1440628848; Louise Radnofsky, *Oregon Backs Hefty Rise in Health-Insurance Premiums*, WALL ST. J. (Jul. 3, 2015), http://www.wsj.com/articles/oregon-backs-hefty-rise-in-health-insurance-premiums-1435873598.

> But innovation has been no match for the actuarial surprises dealt out by the Affordable Care Act. [Geisinger's chief actuary] said Geisinger had simply underestimated how much care its new customers would need.
>
> "Our rates for Medicare, Medicaid and employer-sponsored insurance have been relatively stable, but those products have to bear the cost of our losses on exchange business," [Geisinger's chief actuary] said.
>
> Last October the Pennsylvania Insurance Department… approved a 20 percent increase in Geisinger's rates, about half of what the company had requested.
>
> "But based on experience," [Geisinger's chief actuary] said, "the 2016 premium rate is too low, so we want to correct it in 2017."[24]

On top of regulatory changes, the healthcare-economics consensus since even before the ACA is that value-based care and reimbursement should replace the traditional fee-for-service model. This "revolution"[25] also substantially changes the marketplace and how competition authorities must analyze it. Commentators have noted that switching to this new model has driven mergers between hospitals, acquisitions of physician groups by hospital systems, and even the vertical integration of plans and hospitals.[26]

As even Dafny herself has stated,

> [b]ut has the landscape changed since the Affordable Care Act was passed?... **Clearly, we need additional systematic research to address the many unanswered questions about whether and where consolidation might harm or help consumers**.[27]

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[24] Robert Pear, *Why Do Health Costs Keep Rising? These People Know*, Id.

[25] *See* Michael L. Millenson, *The "Show Me the Value" Health Care Revolution*, 1(3) HEALTH MGMT., POL., & INNOVATION 45 (2013), *available at* http://www.hmpi.org/pdf/HMPI%20-%20Millenson,%20Revolution.pdf. *See also, e.g.,* Leavitt Partners, *Projected Growth of Accountable Care Organizations*, White Paper (Dec. 2015), *available at* http://leavittpartners.com/2015/12/projected-growth-ofaccountable-care-organizations/ (noting that the number of Accountable Care Organizations ("ACOs") increased from 157 in March 2012 to 782 in December 2015, and the number of lives covered by ACOs increased from approximately 7 million in March 2012 to 23 million in December 2015).

[26] *See* Beth Kutscher, *Healthcare merger and acquisition activity likely to stay strong in 2016*, MODERN HEALTHCARE (Jan. 1, 2016), *available at* http://www.modernhealthcare.com/article/20160101/MAGAZINE/301029931.

[27] Leemore Dafny, *The Risk of Health Insurance Company Mergers*, HARV. BUS. REV. (Sept. 24, 2015), https://hbr.org/2015/09/the-risks-of-health-insurance-company-mergers. (Emphasis added).

Indeed. And for the same reason, more study — and a keener awareness for changed circumstances — is needed before proclaiming that past analyses can tell us anything useful at all about the current, proposed mergers.

Even on its own terms the Dafny, *et al.* study is ambivalent

In *Paying a Premium*, Dafny, *et al.* analyzed the basic statistical relationship between concentration (measured by HHIs) and premium price growth between 1998 and 2006, as well as the specific effects of the 1999 merger between Aetna and Prudential on market concentration and premium growth rates in 139 local markets in the United States. The authors then used the results of the Aetna/Prudential case study to estimate more directly the effects of health insurance mergers on simulated data across the entire eight-year period on both premiums as well as provider compensation.

While the paper is consistently cited to demonstrate that insurer consolidation has resulted, and will result in the future, in higher premiums for consumers and lower payouts to providers — a combination that is interpreted to imply the anticompetitive exercise of market power — in fact the paper's conclusions are not so clear, even on its own terms. Moreover, its conclusions may actually have little or no relevance to the assessment of current or future mergers in the industry.

Even taken at face value it must be noted that the paper is a thin reed on which to hang purported systemic and substantial inferences. As the authors themselves note, "[w]e caution that our analysis relies on a single merger whose substantial effects on market concentration persisted for just two years."[28]

While extrapolation from a single case study may be illuminating, it's hardly "*compelling*" evidence that the "effect of market concentration in commercial insurance markets indicates that insurance mergers have led to higher premiums for consumers."[29] And, while widely cited to support the claim of "substantial" effects, it is not so clear that the effects were substantial at all.

The case study's most dramatic, and oft-cited, conclusion is that

> [o]ur… estimates… imply that the average market-level changes in HHI between 1998 and 2006 resulted in a premium increase of approximately 7 percentage points by 2007, ceteris paribus.[30]

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[28] *Paying a Premium*, *supra* note 1, at 1184.

[29] American Antitrust Institute, *supra* note 7, at 4.

[30] *Paying a Premium*, *supra* note 1, at 1184.

To begin with, Dafny, *et al.* point out in a footnote that

> [i]f one assumes that an increase in concentration… affects premium growth for only two years ([] rather than indefinitely), then the implied increase in premiums caused by the increase in [concentration] is somewhat lower at 5 percent.[31]

Because of the design of the study, the authors observed effects of increased concentration on premiums following the Aetna/Prudential merger for only two years. It is *possible* that the effects lasted longer than two years, but the study does not actually demonstrate a longer effect, so five percent would seem to be the more appropriate number.

Moreover, that's a *cumulative* effect of 7 (or 5) percent over the entire period studied, which was 8 years. Over the same period inflation-adjusted premiums increased by 54 percent, meaning that only about one-eighth (or one-eleventh) of premium increases during that period could be attributed to increased concentration at all.

Meanwhile, the results are sensitive to the particular prices and concentration measures during the specific period studied. With a shorter or longer timeframe, or with different start and end points, the results could vary substantially (in either direction, of course). The same is true for the particular geographic and product market definitions implied by the study, which may or may not be appropriate for any particular merger or for today's competitive realities. As even Dafny, *et al.* point out, the effects identified in the paper were limited

> primarily [to] large, multistate firms, and **the results may not be generalizable to all market segments**, including the small group and individual markets.[32]

The markets at issue today in the proposed mergers are not primarily this "employer-sponsored" insurance market. Any lessons to be drawn from this case study are surely limited in applicability for today's mergers.

As one healthcare industry analyst notes regarding the Anthem/Cigna merger:

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[31] *Id.* at 1178 n.30.

[32] *Id.* at 1184. (Emphasis added).

> The studies of health insurance consolidation using the Herfindahl-Hirschman Index (HHI) tend to ignore how different market segments have different competitive structures. For example, the Anthem/Cigna merger would have the greatest impact on HHI in Anthem states, but while Anthem is strong in the individual and small group market, Cigna is not.
>
> Removing Cigna from these segments will have minimal impact on choice. In the large group market where Anthem and Cigna do compete heavily, major employers still have strong negotiating leverage and a sufficient number of choices (United, Aetna, Anthem and/or a local Blue plan).[33]

The Aetna/Humana merger, for its part, will primarily affect the Medicare and Medicare Advantage (MA) market. Among other things, competition authorities will have to consider whether or not traditional Medicare and Medicare Advantage are in the same market. Claims that they are not are troubling. There is important evidence that MA plans compete with traditional Medicare: Most notably, they are marketed as substitutes and there is considerable switching between the two.[34] While some critics point to previous Department of Justice enforcement actions[35] and studies[36] that suggest that Medicare Advantage is its own market, a number of economists and commentators (to say nothing of the CMS itself) plainly consider

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

[34] *See, e.g.*, Consent Order, In the Matter of Application for the Indirect Acquisition of Humana Health Insurance Company of Florida, Inc., Humana Medical Plan, Inc., Careplus Health Plans, Inc., and Compbenefits Company by Aetna, Inc., Case No. 185926-16-CO (Feb. 15, 2016), at ¶ 20, *available at* http://www.floir.com/siteDocuments/AetnaHumanaAcquisition185926-16-CO.pdf.

[35] *See* Complaint, United States of America v. UnitedHealth Group, Inc. & Sierra Health Services, Case 1:08-cv-00322-ESH, at ¶¶ 15-18 (D.D.C., Feb. 25, 2008,), *available at* https://www.justice.gov/atr/case-document/file/514126/download; Complaint, United States of America v. Humana, Inc. & Arcadian Management Services, Case 1: 12-cv-00464, at ¶¶ 20-21 (D.D.C., Mar. 27, 2012), *available at* https://www.justice.gov/atr/case-document/file/499076/download.

[36] *See* Abe Dunn, *Does Competition Among Medicare Advantage Markets Matter?: An Empirical Analysis of the Effects of Local Competition in a Regulated Environment* (Economic Analysis Group Discussion Paper, Jul. 2009), *available at* https://www.justice.gov/sites/default/files/atr/legacy/2009/07/27/248399.pdf (DOJ study finds that as MA plans enter the market, the number of enrollees served and product proliferation increase. This may suggest that traditional Medicare is a separate market because it does not adequately incentivize competition without entry from more MA plans).

Medicare and MA as competitors within a single market.[37] Regardless, a case study about employer-sponsored insurance will have limited applicability to this determination, and to this market.

In short, the extrapolated, long-term, cumulative, average effects drawn from 17-year-old data may grab headlines, but they really don't tell us much of anything about the likely effects of a particular merger today, or about the effects of increased concentration in any particular product or geographic market.

By way of reference, Dafny, *et al.* found average premium price increases from the 1999 Aetna/Prudential merger of 0.25 percent per year for two years following the merger in the 139 geographic markets they studied.[38] "Health Insurance Mergers May Lead to 0.25 Percent Price Increases!" isn't quite as compelling a claim, but it is arguably more accurate (and more relevant) than the 7 percent number merger critics like to throw around.

While none of this necessarily undermines the paper's limited, *historical* conclusions, it does counsel extreme caution for inferring the study's applicability to today's proposed mergers.

The study suffers from some empirical limitations, as well

A changed regulatory environment alone is not the only thing suggesting that past is not prologue. When we delve into the paper more closely we find even more significant limitations on the paper's support for the claims made in its name, and its relevance to the current proposed mergers.

To begin with, although *Paying a Premium* is practically the only work (and certainly the most significant) cited to support the inference that the proposed mergers will have harmful consequences, the study's empirical evidence, even

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[37] *See, e.g.*, AVALERE HEALTH LLC, MEDICARE ADVANTAGE: 2016 NATIONAL SNAPSHOT (May 2015), *available at* http://avalere.com/expertise/managed-care/insights/medicare-advantage-2016-national-snapshot; Medpac, *The Medicare Advantage program: Status report*, *in* REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 327 (Mar. 2016), *available at* http://www.medpac.gov/documents/reports/chapter-12-the-medicare-advantage-program-status-report-(march-2016-report).pdf ("The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the traditional FFS Medicare program. The Commission strongly supports the inclusion of private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and alternative delivery systems that private plans can provide.").

[38] *Paying a Premium*, *supra* note 1, at 1176.

limited as it is, is hardly unambiguous or uncontested. In fact, the authors themselves point out that

> **there is no significant association between concentration levels and premium growth**…. Premiums are not rising more quickly in markets experiencing the greatest increases in concentration, even controlling for a rich set of observable plan characteristics.[39]

It is only when they looked at simulated data derived from the observed effects of the 1999 Aetna/Prudential merger that the authors were able to identify *any* effect of consolidation on premium increases.

Yes, they note, extrapolating from the merger case study a seven percent price increase over eight years in their sample seem to be attributable to increased concentration. But, as noted, that effect amounts to only one-eighth of the observed premium increases over the time period studied. In other words, there were other, substantially more significant factors contributing to premium increases, any number of which may well have become even more significant in the current health insurance market. Similarly, the authors do not fully address the possibility that regulatory or other changes were driving *both* the observed premium increases as well as the observed market concentration increases.

Even in well-instrumented statistical analyses, correlation doesn't necessarily mean causation.[40] While Dafny, *et al*. are quite careful in their analysis, they nevertheless leave out explicit consideration of some potentially dispositive variables.

For instance, the authors do not appear to control for the possible effects of Any Willing Provider ("AWP") laws, which were in effect in a number of states between 1998 and 2006. Considerable scholarship suggests that, by limiting the ability of insurers to negotiate with providers, AWP laws may increase

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[39] *Id.* at 1169, 1184. (Emphasis added).

[40] *See, e.g.*, Aviv Nevo & Michael Whinston, *Taking the Dogma Out of Econometrics: Structural Modeling and Credible Inference*, The Center For The Study Of Industrial Organization Working Paper #0104 (Feb. 25, 2010), at 7, *available at* http://faculty.wcas.northwestern.edu/~mdw054/papers/WhinstonNevoPaper.pdf. ("A second difficulty is that the treatment effect approach requires that the mergers effectively be exogenous events. But mergers are an endogenous choice of firms that may be motivated, in part, by past, current, or anticipated future changes in unobservable (to the researcher) market conditions.").

reimbursement rates, which may then be passed on to subscribers in the form of higher premiums.[41] As health policy economist, Paul Ginsburg, notes:

> Creation of a provider network can achieve lower prices for health plan enrollees because the plan is creating a wholesale mechanism for purchasing services…. This approach to gaining lower prices for enrollees will not work as well [under AWP laws]…. Network creation can [also] reduce health spending for enrollees in ways beyond obtaining lower prices…. [But] AWP laws interfere with the ability of health plans to… make decisions on which providers to seek to include in the network or whether to drop some from the network, thus raising health insurance premiums and undermining quality of care.[42]

If correct, the existence and effects of such laws should be taken into account, particularly if any were implemented or amended at some point during the period studied (as, in fact, several were).[43]

While AWP laws would thus also tend to correlate with increased provider compensation, all else equal, the fact that Dafny, *et al.* found the opposite effect overall does not negate the possibility that their observed premium price effects were being driven by markets with strong AWP laws, while their observed provider compensation effects were being driven more strongly by markets with weak or no AWP laws — precisely because the study doesn't differentiate between the two.

Dafny, *et al.* aren't the only ones to exclude seemingly crucial variables. Another recent study, for example, purports to find a plausible causal link between higher concentration and lower coverage rates (output volume) in individual insurance markets.[44] What the authors do not seem to address, however (even though they acknowledge *other* possible problems with their causal inference), is that we would expect to see the same relationship in geographic markets with higher risk pools,

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[41] *See,* Michael G. Vita, *Regulatory Restrictions on Selective Contracting: An Empirical Analysis of 'Any Willing Provider' Regulations*, 20 J. HEALTH ECON. 955 (2001). *See also* Jonathan Klick & Joshua D. Wright, *The Effect of Any Willing Provider and Freedom of Choice Laws on Prescription Drug Expenditures.* 17 AM. L. ECON. REV. 192 (2015).

[42] Paul B. Ginsburg, *Analysis: How Any Willing Provider Makes Health Care More Expensive* 2, AMERICA'S HEALTH INSURANCE PLANS (Sept. 23, 2014), *available at* https://www.ahip.org/wp-content/uploads/2014/09/MA-White-papers_1.pdf.

[43] *See* Ashley Noble, *Any Willing or Authorized Providers*, National Conference of State Legislatures (Nov. 5, 2014), http://www.ncsl.org/research/health/any-willing-or-authorized-providers.aspx.

[44] Laurie J. Bates, James I. Hilliard, & Rexford E. Santerre, *Do Health Insurers Possess Market Power?*, 78 SOUTHERN ECON. J. 1289 (2012).

too. That is, premiums would be higher, fewer policies would be issued (pre-ACA mandate, at least), and a smaller number of firms that specialize in the financing, pricing and marketing of higher-risk policies would be present.

Interestingly, it should be noted, this study concluded that insurers do *not* appear to possess market power in the market for *employer-sponsored* insurance[45] — in direct conflict with the implications of *Paying a Premium*.

The conclusion that market power is increased through mergers — that is, increased *size* — in *Paying a Premium* may also be incorrect if size happens to be correlated with other determinants of market power in the study's sample. In fact, another study found that insurers do *not* possess market power (monopsony power) in the input (provider) market as a result of market concentration.[46] Rather, this study indicates that insurer market power in the provider market arises, when it does, where insurers can direct patients to particular providers through managed care organizations. The degree of insurer control "depends on factors such as the restrictiveness of its network and the degree to which its coverage rates differ between in-network and out-of-network providers."[47]

This result is particularly important given the focus on size — concentration — inherent in most criticisms of the pending health insurer mergers. Yet,

> The impact on [reimbursement] discounts of a one standard deviation increase in a payer's ability to channel patients is roughly **eight times larger** than the impact of an equivalent increase in payer size…. [S]ubstitution opportunities are more important than size in determining insurers' bargaining power.[48]

This is particularly important to an accurate understanding of *Paying a Premium*, because the study assumes that the competitive effects of a specific merger that was

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[45] *See id.* at 1296 ("More important for the research at hand is the estimated inverse relationship between the health-insurer HHI and IPI, a relationship that does not hold for ESI [Employer-Sponsored Insurance]. It may be the case that, on average, health insurers' monopoly-like market power is effectively mitigated by countervailing power in the ESI market.").

[46] *See* Alan T. Sorenson, *Insurer-Hospital Bargaining: Negotiated Discounts in Post-Deregulation Connecticut*, 51 J. of Indus. Econ. 469, 488 (2003) ("The econometric results of this study suggest the impact of a payer's size on bargaining clout is small relative to the impact of a payer's willingness and/or ability to channel its patients to selected hospitals. The greater relative importance of patient channeling helps explain why small managed care organizations are often able to extract deeper discounts from hospitals than very large indemnity insurers.").

[47] *Id.* at 470.

[48] *Id.* at 472, 473. (Emphasis added).

largely focused on increasing the insurer's managed care coverage can be applied to make inferences about insurer market power more broadly. But if the premium price effects arising from the Aetna/Prudential merger were largely a function of greater insurer control through managed care instead of size, the use of that merger to estimate effects of the corresponding increase in concentration in other markets or at other times may be inappropriate.

The neglected importance of enhanced bargaining power

In general, of course, increasing healthcare costs, whether due to provider consolidation or other factors, could be driving increased premiums. If healthcare *provider* markets are not competitive, even if health insurance markets are, increases in premiums would be expected as the cost of claims rise.[49]

In yet another study that finds that insurers do not possess market power in provider markets, the authors note that

> Taking all of the empirical results together, **it appears that health insurers do not engage in monopsony behavior**. The relationships between buyer concentration and the six different measures of hospital services are either direct or statistically insignificant. Consequently, it appears that much of the attention being paid to consolidations among health insurers may largely reflect that health care providers are trying to protect their monopoly rents.[50]

If health insurance consolidation tends to follow health care provider market power (which seems quite plausible), then, on average, health insurance consolidation will tend to correlate not only with higher premiums but *also* with gains to consumer welfare from reducing health care costs and premiums below what they would have been *without* consolidation.

And, indeed, a considerable body of literature suggests that the enhanced bargaining power wielded by merged health insurers can actually contain price increases that might otherwise arise from healthcare providers exercising their own market power. Some of this literature even goes so far as to suggest that healthcare costs are effectively contained only by *highly* concentrated insurer markets:

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[49] *See generally* Cassandra R. Cole, Enya He, & J. Bradley Karl, *Market Structure and the Profitability of the U.S. Health Insurance Marketplace: A State-Level Analysis*, 34 J. OF INS. REG. 87 (2015) (using state-level data to argue that health care cost increases were the main contributor to higher premiums).

[50] Laurie J. Bates & Rexford E. Santerre, *Do health insurers possess monopsony power in the hospital services industry?*, 8 INT. J. HEALTH CARE FIN. 1, 10 (2008). (Emphasis added).

> **[C]ontrary to conventional wisdom, very few hospitals operate in markets with only a few dominant health plans**. Our statistical results show that although higher health plan concentration is associated with lower hospital prices on average, this relationship is not constant. In fact, hospital prices are significantly affected only when health plan [HHIs are in the "highly concentrated" range]. **These findings lend support to the argument that highly concentrated health plan markets can lead to lower provider prices**.[51]

As noted above, other studies suggest that increased health insurance market concentration does not generally lead to monopsony power, but, rather, that the primary effect is to increase insurer bargaining power against potentially monopolistic providers.[52] One study, for instance, found that

> **Increases in insurance market concentration are significantly associated with decreases in hospital prices**, whereas increases in hospital concentration are non-significantly associated with increases in prices. **A hypothetical merger between two of five equally sized insurers is estimated to decrease hospital prices by 6.7%**.[53]

Given increasing hospital concentration, *even when it is the product of a shift toward value-based health care*, this result is not surprising:

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[51] Glenn A. Melnick, Yu-Chu Shen, & Vivian Yaling Wu, *The Increased Concentration Of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices*, 30 Health Affairs 1728, 1731 (2011). (Emphasis added).

[52] *See, e.g.*, Bates & Santerre, *supra* note 50; William B. Vogt & Robert Town, *How has hospital consolidation affected the price and quality of hospital care?*, Research Synthesis Report No. 9, Feb. 2008, *available at* https://people.emich.edu/jthornton/text-files/Econ436_article_HospitalMergerStudies.pdf.

[53] Asako S. Moriya, William B. Vogt, & Martin Gaynor, *Hospital prices and market structure in the hospital and insurance industries*, 5 Health Econ. Pol. & L. 459, 459 (2010). (Emphasis added).

> Private payers, in contrast, need to negotiate reimbursement rates with health care organizations. With less negotiating leverage as a result of consolidation, private insurers may find it more difficult to leverage cost savings into reduced reimbursement for the health care organization. An integrated health system may reduce costs by 10% to 20%, but it is uncertain whether doing so will translate into lower charges to private insurers.[54]

On the basis of such evidence, even Dafny is forced to admit that

> **In settings where both sides possess market power and bargain over prices, an increase in buyer power can reduce price without reducing output (or, equivalently, without leading to a deterioration in quality)**. Indeed, two other studies of monopsony focusing on hospitals — an industry that is concentrated in many areas — find areas with higher insurer HHIs (higher concentration) have higher, not lower, hospital utilization.[55]

Critics nonetheless sometimes argue that historical data indicates that savings are not passed on to consumers, as merged insurance companies increase premiums anyway. Some, like the American Antitrust Institute's Thomas Greaney, dismiss enhanced bargaining power as a cognizable efficiency in antitrust analysis at all, derisively labelling it the "Sumo Wrestler Theory."[56] Greaney offers a couple of anecdotes of large providers and insurance companies entering into allegedly anticompetitive deals to undermine consumer benefit — even as he cites evidence suggesting that insurance companies do indeed hold down price increases from powerful providers.[57] But if collusion between insurers and providers occasionally impedes the realization of these benefits, then antitrust agencies should use the Sherman Act to challenge that conduct when and if it occurs; they should not challenge or impede welfare-enhancing mergers that are unlikely to lead to such problems in the first place.

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[54] David M. Cutler & Fiona Scott Morton, *Special Communication: Hospitals, Market Share, and Consolidation*, 310 J. AM. MED. ASS'N 1964, 1968 (2013).

[55] Dafny, *supra* note 9, at 5. (Emphasis added).

[56] Greaney, *supra* note 15.

[57] *Id.* (citing Melnick, Shen, & Yaling Wu, *supra* note 51).

The role of entry in the post-ACA world

While, as noted, Dafny likes to (somewhat selectively) argue that past is prologue,[58] the market and the regulatory environment in which the market operates are enormously different than they were during the period (1998 to 2006) analyzed in *Paying a Premium*. The regulatory landscape has significantly changed how insurers can run their businesses, likely limiting their profits[59] and their ability to deal with risk[60] considerably. Moreover, since the new health insurance exchanges have reduced barriers to entry, the threat of competition between insurers in individual markets and those in employer-sponsored markets makes it more likely that any savings realized by health insurers will be passed on to consumers. As noted in a 2014 Brookings Institution paper:

> Since the subsidies are only available in the individual health insurance market, while they decrease demand in other markets, they increase demand in the individual health insurance market.[61]

During the time period analyzed in *Paying a Premium*, consumers may have been unlikely to substitute out of tax-favored, employer-sponsored plans in response to relatively small premium increases. But that reluctance is surely ameliorated today where, for many people, individual plans are now subsidized. Whether the ACA's subsidies are substantial enough to mitigate the possible competitive concerns arising in the specific cases or particular markets involved in either of the current proposed mergers is an empirical question, to be sure. But it's one — *among many others* — that previous studies simply do not answer.

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[58] Dafny Testimony, *supra* note 2, at 9.

[59] *See Medical Loss Ratio*, CENTERS FOR MEDICARE & MEDICAID SERVICES (last accessed Apr. 19, 2016), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html.

[60] *See* Ursula Taylor, *Spreading the Risk under the Patient Protection and Affordable Care Act: The Three Rs and Lessons from Another Industry's Reinsurance Mechanism*, ABA HEALTH ESOURCE, vol. 12, no. 2, *available at* http://www.americanbar.org/publications/aba_health_esource/2015-2016/october/spreadingtherisk.html ("Risk-sharing mechanisms under the Patient Protection and Affordable Care Act of 2010 (PPACA) are intended to smooth risk across health plans and neutralize the potentially disproportionate risks and costs anticipated as a result of PPACA requirements.").

[61] Amanda E. Kowalski, *The Early Impact of the Affordable Care Act, State by State* 282 (Brookings Papers on Economic Activity, Fall 2014), *available at* http://www.brookings.edu/~/media/Projects/BPEA/Fall-2014/Fall2014BPEA_Kowalski.pdf.

Meanwhile, in many markets insurance companies integrated with health networks have gained an advantage.[62] In fact, competitive entry is occurring by vertically-integrated healthcare provider networks,[63] as well as new insurance companies entering into individual health insurance exchanges.

And, especially under the ACA, insurers in individual and small group markets (at least) will likely face increasing price discipline from health networks offering insurance themselves.[64] As Peter Orszag, President Obama's former OMB director and an ACA advisor, acknowledged:

> If you're a… hospital, and all of a sudden you're being moved towards a capitated system [through greater pressure to offer accountable care], you're effectively an insurance company.[65]

Recognizing this, provider-offered insurance is becoming increasingly common. According to one McKinsey report, "13 percent of all US health systems offer health plans in one or more markets… [and] provider-led plans are currently present in 39 states."[66]

As the report makes clear, vertically integrated provider/payers face risks, of course. But regulatory incentives and market competition are nevertheless increasingly pushing providers in that direction. As one scholar notes:

> Arranging for comprehensive health care at affordable prices was the expected role for HMOs from the 1970s into the 1990s and is a desired outcome of the current move toward ACOs.[67]

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[62] *See, e.g.*, Jeff Manning, *Insurers lose, hospitals win in Affordable Care Act shakeout*, THE OREGONIAN (Mar. 4, 2016), http://www.oregonlive.com/business/index.ssf/2016/03/insurers_lose_hospitals_win_in.html.

[63] *See* Austin Frakt, *When Hospital Systems Buy Health Insurers*, THE NEW YORK TIMES (May 25, 2014), http://www.nytimes.com/2014/05/26/upshot/when-hospital-systems-buy-health-insurers.html.

[64] *See, e.g.*, Michelle Andrews, *Health Systems Dipping Into The Business Of Selling Insurance*, KAISER HEALTH NEWS (Nov. 10, 2015), http://khn.org/news/health-systems-dipping-into-the-business-of-selling-insurance/.

[65] Peter Orszag, *Health Spending in 2014: Keep Your Eye on the Medicare Ball* (Keynote Address at the Gateway Seminar: The Reform Landscape of Health Care Delivery, Aug. 26, 2014), *available at* https://www.youtube.com/watch?v=yjJR1BX3Uio&feature=youtu.be&t=34m.

[66] GUNJAN KHANNA, EBBEN SMITH, & SAUM SUTARIA, PROVIDER-LED HEALTH PLANS: THE NEXT FRONTIER—OR THE 1990S ALL OVER AGAIN? 3 (McKinsey & Company 2015), *available at* http://healthcare.mckinsey.com/sites/default/files/Provider-led%20health%20plans.pdf.

[67] Sage, *supra* note 17, at 665.

In Pittsburgh, for instance, the breakdown of the contract between long-time partners UPMC and Highmark was in part driven by UPMC's decision to provide its own health insurance option (as well as Highmark's decision to build its own health system).[68] And a recent merger between hospital systems in Chicago (currently being challenged by the FTC) has been defended in part on the ground that the merged entity will be able to offer a health insurance option up to 10% less expensive than the cheapest HMO plan in the region.[69]

In short, deriving predictions regarding future mergers from statistical analysis of past mergers is a tenuous exercise:

> Of course, if we had previous experiences with all possible types of mergers (and could distinguish them), we could answer all these questions by looking at past outcomes. But given the many possible circumstances of a merger, it seems inevitable that many possible proposed mergers will not have been seen and studied before. In that case, to use past mergers to predict future outcomes one needs a model. This model can be a statistical model or it can be an economic model. A statistical model… would seek to predict the outcome of a merger using either a group of not-too-dissimilar mergers…, or more generally fitting some prediction function based on a set of observable merger attributes…. [T]his will often be a difficult task to do in a convincing manner, even when some mergers have previously been observed in an industry.[70]

To be sure, the intractable complexity and enormous uncertainty that characterize these markets necessarily make predictions regarding the competitive effects of new entry and new business models difficult. But, for the same reason, conclusions based on historical analyses, and especially on the presumed relationship between concentration and performance derived from them, are also extremely unreliable.

Conclusion

In light of the limited relevance of the historical evidence and the statistical analyses that rely on it, as well as the massive regulatory changes brought about

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[68] Rob Cullen, *When health care giants collide: UPMC vs. Highmark*, WHAT IF POST (Nov. 14, 2011), http://whatifpost.com/when-health-care-giants-collide-upmc-vs-highmark.htm.

[69] Ameet Sachdev, *What's at stake as FTC heads to trial to stop Advocate-NorthShore hospital merger*, CHICAGO TRIBUNE (Apr. 8, 2016), *available at* http://www.chicagotribune.com/business/ct-advocate-northshore-ftc-0410-biz-20160408-story.html.

[70] Nevo & Whinston, *Taking the Dogma Out of Econometrics*, *supra* note 40 at 6.

by the ACA, critics have not made a compelling case that the proposed health insurance mergers will harm consumers.

Perhaps the most important corrective to the pervasive use (or misuse) of analyses like *Paying a Premium* to justify thwarting health insurer market consolidation is a better understanding of the complicated and unique determinants of competitive effects in health insurance and healthcare markets. But this understanding is elusive, and regulation or policymaking in its absence is likely to be deeply flawed.

Whatever the merits of studies looking at readily observed data like HHIs, provider reimbursement rates and premium prices, they simply do not capture the real market dynamics and the most relevant statistics:

> To put it bluntly, there is an almost complete lack of understanding of how much it costs to deliver patient care, much less how those costs compare with the outcomes achieved.[71]

And, as William Sage forcefully notes, with respect to antitrust enforcement in such an environment,

> Basing enforcement priorities on predictive models that rely so heavily on past conditions is likely to be misleading at best, and at worst to cause substantial harm by chilling productive innovation. The United States is now experiencing another discontinuity in regulation and payment, with profound implications for health care markets. Much as government has heavily influenced market structure, conduct, and performance in the past, changes in regulation will influence future competitive outcomes as the ACA is implemented.[72]

While his comments were offered with respect to the antitrust analysis of provider markets in particular, they apply at least as much to health insurance markets, as well.

To the extent that conclusions about mergers — by insurers and providers alike — are drawn from concentration/price studies like *Paying a Premium*, they are likely to perpetuate the simplistic and inaccurate view of health care and health insurance markets, to the great disadvantage of consumer welfare.

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[71] Robert S. Kaplan & Michael E. Porter, *The Big Idea: How to Solve the Cost Crisis in Health Care*, HAR. BUS. REV., Sept. 2011, *available at* https://hbr.org/2011/09/how-to-solve-the-cost-crisis-in-health-care/ar/1.

[72] Sage, *supra* note 17, at 652.