STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF THE ACQUISITION OF CONTROL OF OXFORD HEALTH PLANS (NJ), INC. BY UNITEDHEALTH GROUP INCORPORATED	))))	HEARING OFFICER'S REPORT

Procedural History

In accordance with N.J.S.A. 17:27A-2, on May 8, 2004, as supplemented through May 25, 2004, United HealthGroup Incorporated (hereafter referred to as "United" or "applicant") filed with the Department of Banking and Insurance ("Department") an application to acquire control (hereafter referred to as the "Form A" filing) of Oxford Health Plans (NJ), Inc. (hereafter referred to as "Oxford"), a New Jersey domiciled health maintenance organization ("HMO").

Oxford was incorporated and commenced business on April 15, 1985. It is authorized to operate as an HMO in New Jersey. Oxford writes commercial and Medicare business pursuant to State law. Oxford is a direct, wholly-owned subsidiary of Oxford Health Plans, Inc.

Pursuant to N.J.S.A. 17:27A-2d, a public hearing was held on the Form A filing on July 13, 2004 at 20 West State Street, Trenton, New Jersey. The following persons appeared and testified as witnesses:

Robert J. Sheehy, CEO, United HealthCare Inc.;

Charles Berg, President and CEO, Oxford Health Plans;

Michael J. McDonnell, General Counsel, United HealthCare Inc.;

David Lubben, General Counsel, UnitedHealth Group;

Robert Oberrender, Vice President and Treasurer, UnitedHealth Group;

Daniel Gregoire, General Counsel, Oxford Health Plans;

Marc Kole, Senior Vice President, Finance, Oxford Health Plans;

Victoria Bogatyrenko, Chief Operating Officer, United HealthCare;

Monica Noether, Vice President, Charles River Associates, Inc.; and

George Dytyniak, Manager, Office of Solvency Regulation, Department of Banking and Insurance.

The following members of the public provided testimony:

Lawrence Downs, J.D., representing the Medical Society of New Jersey ("MSNJ"); Maria Menonna on behalf of MSNJ; and Lorraine Bomba on behalf of MSNJ.

The record was held open until July 26, 2004 at the request of the MSNJ and United for the purpose of submitting a market analysis, and for any interested parties to submit written comments.

MSNJ submitted supplemental information in opposition to the merger dated July 22, 2004. In addition, written comments were submitted dated July 22, 2004 from Michael D. Maves, MD, MBA on behalf of the American Medical Association ("AMA"). The AMA's comments referenced and reiterated the general comments of MSNJ.

Written comments were also submitted by Liberty Health and the New Jersey Chapter of the Healthcare Financial Management Association, both expressing concern with the impact of the proposed merger on the citizens and

healthcare providers in the State; and Beattie Padovano, LLC, expressing its opposition to the merger. A written comment from Patrick Daugherty questioned the connection between the founder and former President of Oxford Health Plan and the applicant, and the circumstances of his leaving Oxford Health Plan. The last documents were received from United on July 23, 2004, and the record formally closed on July 26, 2004.

Findings of Fact

The applicant is a publicly traded Minnesota general business corporation. It is the ultimate parent of all of the UnitedHealth Group entities. The applicant was incorporated on January 25, 1977 as a Minnesota general business corporation, and is not qualified to do business in any other jurisdiction since it functions primarily as a holding company. The applicant is engaged in designing, organizing and managing health and well-being services, and currently serves approximately 52 million Americans through its subsidiary insurers, health maintenance organizations, third party administrators and other service providers. The applicant provides individuals with access to health care services through more than 400,000 physicians and 3,600 hospitals across the United States. The applicant manages approximately $50 billion in aggregate health care spending. United states that its primary focus is on improving the American health care system by simplifying the administrative components of health care delivery, promoting evidence-based medicine as the standard for care and

providing relevant, actionable data that physicians, health care providers, consumers, employers and other participants in health care can use to make better, more informed decisions. The applicant's revenues are derived from premium revenues on risk-based products; fees from management, administrative and consulting services; and investment and other income. Its operating subsidiaries currently do business in all 50 states, the District of Columbia, Guam, Puerto Rico, the U.S. Virgin Islands and internationally. The applicant conducts its business primarily through four divisions:

1. Uniprise, which provides comprehensive, integrated health benefit services to multi-location employers with more than 5,000 employees. Uniprise also provides claim processing, call processing and other complex transaction processing services to consumers served by UnitedHealthcare;

2. Health Care Services, which consists of the UnitedHealthcare, Ovations, AmeriChoice and Golden Rule businesses. UnitedHealthcare coordinates health and well-being services on behalf of local employers and consumers nationwide, and its products are primarily marketed to small and mid-size employers with up to 5,000 employees. UnitedHealthcare also administers funds for its self-insured customers. Its products are offered through affiliates that are usually licensed as insurers or as health maintenance organizations, or as a third-party administrator for self-funded customers. Ovations provides health and well-being services for Americans age 50 and older in all 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands through licensed affiliates. AmeriChoice works

exclusively with selected states to provide health insurance coverage to eligible Medicaid beneficiaries in exchange for a fixed monthly premium per member from the applicable state;

3. Specialized Care Services, which is a portfolio of companies that provide a variety of ancillary health and well-being services, such as mental health, dental, and vision benefits, to more than 23 million individuals. Golden Rule's focus is on providing individual health care services; and

4. Ingenix, which operates in the field of health care information, serving multiple health care markets on a business-to-business basis.

According to the applicant's Form A filing, the applicant will acquire Oxford when the applicant acquires Oxford's ultimate parent company. The acquisition by the applicant will be effected by the merger of Oxford's ultimate parent with and into Ruby Acquisition LLC ("Ruby LLC"), a newly-formed limited liability company organized under the laws of the State of Delaware and wholly-owned subsidiary of the applicant, pursuant to the terms of the Agreement and Plan of Merger dated April 26, 2004. As a result of the merger, the separate corporate existence of Oxford will cease, and Ruby LLC, which will succeed to all the rights and obligations of Oxford, will survive as a wholly-owned subsidiary of the applicant and will be renamed Oxford Health Plans LLC ("Oxford LLC"). Oxford LLC will directly own all of the outstanding voting securities of Oxford, which will become an indirect, wholly-owned subsidiary of the applicant.

Upon completion of the merger, each outstanding share of Oxford common stock, other than shares held by Oxford as treasury stock or held by a person who has not voted in favor of the merger or consented to the merger in writing, and who has demanded appraisal for such shares in accordance with Delaware law, will be converted into the right to receive 0.6357 shares of common stock, par value $0.01 per share, of the applicant and $16.17 in cash. At the hearing, the applicant testified that the Oxford stockholders approved the merger on July 7, 2004.

The applicant's Form A filing indicates a total purchase price of $4.98 billion ($3.36 billion in stock, $1.32 billion in cash, $285 million for the estimated fair value of the applicant's vested common stock options issued in exchange for outstanding Oxford vested stock options, and $15 million of estimated transaction costs). The applicant testified that approximately 82 million shares of Oxford stock will be consolidated through the merger transaction, and that upon closing of the merger, approximately 52.1 million shares of United common stock will be issued. The Form A filing states that as a result of the merger, the applicant will not pledge its own securities or the securities of any of its subsidiaries or affiliates or the securities of Oxford. The applicant testified that on April 23, 2004, United executed a commitment letter with JP Morgan and Chase Bank whereby JP Morgan agreed to provide the applicant with a $2 billion bridge loan to finance the cash portion of the merger consolidation consideration. The bridge loan is 364 days in length effective April 23, 2004. The

applicant further testified that it reserved the right to use cash or cash equivalents on hand at the time to fund part of the merger consideration. United will have the flexibility to borrow directly from the bridge facility and issue commercial paper that is supported by the bridge facility, with maturities in the 30-90 day range; within one to six months of consummation of the transaction, the applicant will refinance the original commercial paper with subsequent issuances of commercial paper or with the proceeds of permanent financing, depending upon market conditions at the time. The applicant testified that United expects the permanent financing to be retained on an unsecured basis with no guarantees or pledges consistent with United's currently outstanding bonds. The applicant testified that it does not anticipate repayment of the bridge loan to have any negative material effect on United's financial standing.

The applicant's Form A filing states that it has no present plans or proposals to declare an extraordinary dividend or make other distributions to liquidate Oxford, to sell any of Oxford's assets (except for investment transactions in the ordinary course of business), to merge or consolidate Oxford with any person or persons, to make any other material change in any of Oxford's business operations or the corporate structure, or to cause Oxford to enter into material contracts, agreements, arrangements, understandings or transactions of any kind with any party (other than those entered into in the ordinary course of business). The applicant intends for Oxford to repay all outstanding indebtedness at or shortly after consummation of the transaction.

Oxford will be contributed to one of United's subsidiaries. Oxford's board of directors and certain executive officers will be replaced. The applicant currently has no plans to discontinue the majority of products presently offered by Oxford, but reserves the right following consummation of the merger to make any changes that it deems appropriate.

As reported in the consolidated annual statements submitted as part of the filing, United had consolidated shareholders' equity of approximately $5.1 billion on December 31, 2003; $4.4 billion on December 31, 2002; and $3.9 billion on December 31, 2001. United also had consolidated net before-tax income of approximately $2.8 billion in 2003 and $2.1 billion in 2002.

Analysis

N.J.S.A. 17:27A-2d(1) provides that the Commissioner of Banking and Insurance ("Commissioner") shall approve an acquisition of control of a domestic insurer[1] unless he or she finds that one or more of the seven disqualifying factors exist. The statute provides in pertinent part:

(1) The Commissioner shall approve a merger or other acquisition of control unless, after a public Departmental hearing thereon, he or she finds that:

(i) After the change of control the domestic insurer . . . would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

[1] The term "insurer" includes a "health maintenance organization" pursuant to N.J.S.A. 17:27A-1e.

(ii) 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 therein [applying the competitive standard as set forth in the statute];

(iii) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders;

(iv) The financial condition of any acquiring party is such that: (a) the acquiring party has not been financially solvent on a generally accepted accounting principles basis, or if an insurer, on a statutory accounting basis, for the most recent three fiscal years immediately prior to the date of the proposed acquisition (or for the whole of such lesser period as such acquiring party and any predecessors thereof shall have been in existence); (b) the acquiring party has not generated net before-tax profits from its normal business operations for the latest two fiscal years immediately prior to the date of acquisition (or for the whole of such lesser period as such acquiring party and any predecessors thereof shall have been in existence); or (c) the acquisition debt of the acquiring party exceeds 50 percent of the purchase price of the insurer;

(v) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or

management, are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(vi) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control; or

(vii) The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

Upon a thorough review of the transcript in this matter and the documents submitted into evidence, the hearing panel and Department staff have determined that none of the seven disqualifying factors set forth above should result if the proposed acquisition is effectuated. Each of these conditions is discussed below.

At the outset, it should be noted that regulatory oversight for HMOs rests with both the Department of Health and Senior Services ("DHSS") and the Department of Banking and Insurance. The Department generally oversees the financial condition of HMOs, and DHSS oversees areas related to delivery of care, such as network adequacy and quality of care. It should be noted that DHSS has reviewed the proposed transaction and has found that it will not adversely impact network adequacy of either entity.

First, following consummation of the transaction, Oxford LLC will meet the requirements to write the line of business for which Oxford is presently licensed

pursuant to N.J.S.A. 26:2J-1 et seq. Oxford was formed and commenced business on April 15, 1985, and is presently licensed. There is nothing in the record from which it may be concluded that after the change of control, Oxford LLC would not be able to satisfy the requirements to continue to maintain its certificate of authority to operate a health maintenance organization in this State.

Second, it does not appear that applicant's acquisition of Oxford will substantially lessen competition in the New Jersey insurance market or tend to create a monopoly. N.J.S.A. 17:27A-2d(1)(ii) provides that in applying this competitive standard, the standard set forth in N.J.S.A. 17:27A-4.1 shall apply. N.J.S.A. 17:27A-4.1d(1) states that "[t]he Commissioner may enter an order [disapproving an acquisition application] . . . if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition . . . or, to tend to create a monopoly therein. . . [.]" N.J.S.A. 17:27A-4.1d(2) states that the Commissioner shall consider one of two complex formulae set forth in the statute in making this determination, dependent upon the market share of the insurers, and whether the market is highly concentrated or not highly concentrated.

N.J.S.A. 17:27A-4.1d(2)(c) allows the Commissioner, even if there is no prima facie violation of the appropriate statutory formula, to establish the requisite anticompetitive effect based on other substantial evidence. Alternatively, the statute states that if there is a prima facie violation of the

formula, the absence of the requisite anticompetitive effect may be established based upon other substantial evidence, including, but not limited to market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry and exit into the market. "Market" is defined to mean "the relevant product and geographical markets as determined by the Commissioner." In determining the relevant product and geographic markets, in the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, as the line is used in the annual statement required to be filed, and the relevant geographical market is assumed to be this State.

N.J.S.A. 17:27A-4.1d(3) states that the Commissioner shall not deny an acquisition application if "(a) The acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from those economies exceed the public benefits which would arise from not lessening competition; or (b) The acquisition will substantially increase the availability of insurance, and the public benefits of that increase exceed the public benefits which would arise from not lessening competition."

Increasing concentration in the commercial health care industry has been a trend both nationally and in New Jersey during the past several years. This concentration has taken the form of specialization by which some companies

have chosen to divest their health care operations, while others have divested or limited related businesses such as life insurance. As a result, larger, specialized companies focused on commercial health care have become more dominant in size and market share. While this trend results in fewer separate entities, those entities are required to offer a wide variety of plan choices, including traditional indemnity health insurance; preferred provider plans ("PPO"); point-of-service plans ("POS"); as well as administrative services only ("ASO") contracts to manage self-insured employer and union health care plans. Substantial resources are required to be committed by these larger, more specialized firms in order to provide this variety of plans, to establish the networks of providers needed to deliver services, and to support the systems necessary to contain administrative costs. The trend toward concentration and specialization further reflects the market pressures to provide health care plan services as efficiently as possible, and to the extent it has done so, most citizens have benefited. Nevertheless, much of the gain in efficiency has come at the expense of providers that agree to provide their services at a discount to the companies' health care plans' members and subscribers. It is against this background that the current application and the objections of the MSNJ set forth below must be analyzed.

To summarize the applicant's position, the merger will not substantially lessen competition in any properly defined market in New Jersey because of a lack of market power that the combined firm would have. The merger should

result in a cost savings for the combined company, allowing it to offer higher quality managed care services at prices lower than either firm could offer individually. The merger should also reduce the administrative burden on physicians and hospitals, allowing them to reduce their practice expenses. The applicant provided a competitive analysis of the proposed merger to support its position.

The applicant's analysis was based on the merger guidelines published jointly by the U.S. Department of Justice ("DOJ") and the Federal Trade Commission ("FTC"), which include standards used by the Federal antitrust agency to assess whether proposed mergers are likely to have adverse competitive consequences. Most state Attorneys General also use the same guidelines. The applicant used all commercial managed care plans as the most likely relevant product market to conduct its analysis, including group and individual health plans and a variety of benefit designs such as HMO, EPO, POS and PPO. The market includes both insured and self-insured plans, and may include indemnity health insurance. The applicant's analysis did not include health plans such as Medicaid HMOs, Medicare HMOs, or Medicare supplemental plans, stating that they involve different customer segments and should be evaluated separately. The applicant stated that in recent years, HMOs and other types of health plans share increasingly similar benefit plan designs. Further, United's and Oxford's HMO enrollment in New Jersey now accounts for only about 11.3% and 14.6% respectively of their total commercial membership in

the State. Regarding the appropriate geographic market, the applicant considered the State as a whole pursuant to New Jersey's statute, and also the 10 individual Metropolitan (or Micropolitan) Statistical Areas ("MSA") as defined by the U.S. Census Bureau that comprise the State. The applicant stated that United's share of premium revenue is about 8.3%, Oxford's share is 7.8%, and that the combined entity would have a 16.1% share. The guidelines indicate that a share less than 35% indicates that no anticompetitive behavior is likely to occur.

The applicant additionally provided extensive analysis on the pre- and post-acquisition Herfindahl-Hirschmann Index ("HHI"). The HHI is utilized as a measure of determining whether a proposed transaction will have adverse competition effects. The applicant's study concluded that, based on a review of various MSAs, no such adverse effects would result from the proposed acquisition.

The applicant further asserted that it is unlikely that the transaction would have any monopsonistic impact on providers in the State, and that providers may, in fact, realize certain benefits following the transaction. Monopsony would be a concern in this instance if a decrease in reimbursement to providers would result in reduced quality of care. The applicant stated for monopsony to exist, there is a fundamental prerequisite that an absence of sufficient alternative purchasers exist. DOJ and FTC guidelines indicate an antitrust safety zone for purchasers that is 35%, similar to the 35% threshold on the sell side. In its

analysis of monopsony power, as opposed to the monopoly analysis, the applicant considered all expenditures in provider services, including public health plans (e.g., Medicare, Medicaid), because the dollars spent on those programs are the same as dollars spent by private payers. The applicant looked at various MSA's where the HHI exceeds 100, and found that the combined company share of expenditures on hospital care never exceeds 7%, and the combined company share of expenditures on physician services never exceeds 9%. Moreover, the applicant stated that providers may realize some benefits from the merger, including reduced administrative accounts and a reduction in the administrative burden of dealing with separate payers. The applicant added that New Jersey legislation, while not yet fully implemented, permits providers to engage in collective bargaining with health insurers, further reducing potentially monopsonistic results from the merger.

The applicant further noted that DOJ announced on July 20, 2004 the closing of its investigation into this proposed merger. The DOJ found that in the tri-state area of New York, New Jersey and Connecticut, "the facts did not support a conclusion that this merger will give a combined United/Oxford market power or monopsony power in the markets in which they compete. The two companies are not particularly close competitors, and consumers will have a number of other choices after the merger. The two companies also do not account for a large percentage of physician or hospital reimbursements in the markets in which they compete. . . ." While the Department is not bound by the

action of this agency, its conclusion is highly probative in assessing this proposed transaction from the perspective of the Department's regulatory responsibilities. Further, we find that it is appropriate to use the DOJ and FTC guidelines in our analysis of the potential anticompetitive effects of the proposed merger.

The MSNJ provided testimony and submitted an independent market analysis opposing the applicant's findings. The MSNJ concluded that New Jersey's market is highly concentrated, particularly in the northern counties, and that this merger will substantially lessen competition in the health insurance market in New Jersey. MSNJ asserted that following the acquisition of U.S. HealthCare and Prudential by Aetna, and the growth of Horizon, the New Jersey health insurance markets are already so concentrated that almost any added merger or acquisition activity will violate New Jersey and Federal standards for maintaining competitive markets.

The MSNJ stated that the relevant product markets include the market for the sale of health insurance and the market for the purchase of physician services, and includes the combined private commercial market for all managed care services. The MSNJ stated that an appropriate test for determining the relevant geographic market is the scope of the parties' activities, thereby concluding that the relevant geographic market for the sale of health insurance is regional, and that the most appropriate regional approximation is the MSA, the CBSA, or a broader "regional" area that divides New Jersey into northern and southern parts of the State. While the MSNJ does not believe that the market for

health insurance and New Jersey is Statewide, it calculated the impact of the proposed merger on a putative Statewide market, concluding that even United's and Oxford's best case argument would violate New Jersey standards regarding competition, as well as the Federal guidelines. The MSNJ further stated that the proposed merger will occur in highly concentrated markets, will produce prima facie evidence that it will substantially lessen competition in health insurance markets in New Jersey and will be prejudicial to the insurance buying public. The likely impact of the merger would be substantial increases in already high levels of premiums paid by employers, even greater health insurer profit levels after record-breaking profits over the past several years, more financial windfalls for United and Oxford executives, and additional action by the combined entity to further reduce physician compensation, while denying contractually committed payments for medically necessary procedures by using claims processing and pattern recognition software that denies payment without any clinical justification. The MSNJ stated that the proposed merger is likely to produce substantial inefficiencies in the form of diseconomies of scale rather than creating efficiencies. The MSNJ also stated that there are substantial barriers to entry in the New Jersey health insurance market. Any harmful effects from the proposed acquisition cannot be dissipated by new entry into the market and the prospect of competition will not be strong enough to deter monopolistic effects. The applicant submitted additional documents in response to the MSNJ's market analysis, which essentially reiterated its initial analysis.

Upon review of the information and testimony provided regarding this issue, the hearing panel and Department staff do not find that the effect of the proposed acquisition would be substantially to lessen competition in the commercial healthcare industry in this State or tend to create a monopoly therein, such as to require that the proposed acquisition be disapproved pursuant to N.J.S.A. 17:27A-2d(ii). Pursuant to that statute, the basis of the analysis is set forth in N.J.S.A. 17:27A-4.1. The first issue to be determined is whether the relevant market is the entire State or regions within the State.

N.J.S.A. 17:27A-4.1d(2)(d) provides that, in the absence of sufficient information to the contrary, the relevant geographical market is assumed to be this State. MSNJ would seek to utilize the northern counties of the State, and based on an analysis of the impact of the proposed acquisition on those counties, that the proposed acquisition should be disapproved. The hearing panel and Department staff believe this argument is unsupported and unpersuasive. There were no facts presented to reasonably conclude that the Commissioner should deviate from the presumptive geographic market other than a statement that the proposed acquisition would result in concentrations in particular counties. While concentration may be greater in particular counties of the State as opposed to others, this does not provide a basis for evaluating solely certain counties in making a determination as to whether a proposed acquisition should be disapproved. Both HMOs are authorized to transact business throughout this State. In addition, New Jersey is one of the smallest States

geographically, the most densely populated State, and is highly urbanized. New Jersey is not like other States, such as Texas, which is very large geographically with isolated areas of high population density, which thus may make it more appropriate to look at particular areas of a State in determining a relevant market. In addition, MSNJ provided no basis by which to determine whether to base the geographic market on individual counties, on various counties combined, or where the demarcation point should exist. Accordingly, absent any clear information to the contrary, the hearing panel and Department staff believe that the statutory standard of the relevant geographic market to be this State.

The next issue to be determined is the relevant product market. N.J.S.A. 17:27A-4.1d(2)(d) provides that, absent sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, as is used in the annual statement required to be filed by insurers or HMOs doing business in this State. MSNJ appears to agree generally with this position. Based on this analysis, on the most recent data available, before the acquisition, United and Oxford had 5% and 8%, respectively, of the HMO commercial market, and 5% and 11%, respectively, of the entire commercial health insurance market. It appears to be more appropriate to consider the entire commercial health insurance market since HMOs compete with health insurers for the provision of health coverage to individuals in this State. Ultimately, as set forth below, this determination will not impact the Department's analysis.

As noted above, N.J.S.A. 17:27A-4.1 uses different formulae in determining whether a proposed acquisition would exceed the stated market shares. One set of formulae is used in case of a highly concentrated market; the other is used in the case where the market is not highly concentrated. Pursuant to N.J.S.A. 17:27A-4.1d(2)(a), a highly concentrated market is one in which the share of the four largest insurers is 75% or more of the market. Based on the most recent data and a review of the four largest HMOs and health insurers, the market shares for both markets exceed 75% of the total market.[2] Accordingly, the appropriate formula to utilize is that which applies to a highly concentrated market. In addition, regardless of whether this analysis applies solely to the commercial HMO or the commercial health insurance market as a whole, the market shares of Oxford and United would exceed the statutory threshold standard set forth at N.J.S.A. 17:27A-4.1d(2)(a). However, the statute requires additional analysis.

N.J.S.A. 17:27A-2d(ii)(b) specifically provides that the acquisition shall not be disapproved where the market shares of the involved insurers exceed the relevant thresholds if the Commissioner finds the acquisition will yield substantial economies of scale or economies in resource utilization that cannot feasibly be achieved in any other way, and the public benefits that would rise from those economies exceed the public benefits which would arise from not lessening

[2] Based on the most recent data available, Oxford currently is the fifth largest commercial HMO in the State with 11% of the market share, while United ranks sixth with 5% of the market share. Post-merger, the combined 13% market share would rank United third. For the health entities market, Oxford currently

competition (See N.J.S.A. 17:27A-4.1d(2)(d)(3)). United stated in its analysis that it believed the proposed acquisition will result in various efficiencies by enabling the combined entity to achieve lower costs than it could have achieved absent the transaction. This would permit the combined entity to offer health plans to employers and individuals at a lower price than they would otherwise been able to provide separately. This would occur through cost savings in two areas: more favorable reimbursement rates for Oxford members using out-of-area providers and other network related savings, and rationalization of administrative functions.

United stated that Oxford has approximately 34,000 members who reside outside of the tri-State area, primarily in Pennsylvania, Florida, California and Massachusetts. United stated that these members reside in states where Oxford does not have an established provider network, and accordingly, they access out of area providers through arrangements that Oxford has with network rental companies. However, United stated that Oxford's out-of-area provider reimbursement rates are higher than reimbursement rates paid by health plans with are larger presence in these areas. Accordingly, Oxford's out-of-area members will be able to access United's nationwide provider network, with corresponding lower reimbursement rates. United also cited the elimination of duplicated overhead. In addition, United stated that the proposed transaction has the potential to reduce the administrative burden for providers by allowing

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ranks third with 11% of the market share, while United ranks sixth with 5%. Post-merger, the combined 16% health entities market share would rank United as the third largest.

physicians and hospitals that provide health care services to members of both United and Oxford to submit a single type of claim form for reimbursement.

Regarding proposed efficiencies, MSNJ stated that the applicant's statements regarding the anticipated cost savings and administrative efficiencies of the merger are based solely on self-reported estimates from United and Oxford, and that the applicant presented no objective criteria to justify those predictions. The applicant's expert testimony indicated that internal company documents were not the only source in analyzing the cost savings and efficiencies, but also included the expert's discussions with business executives about the source of the efficiencies to ensure consistency with other transactions. Further, the statements regarding the cost savings and efficiencies are public documents available to the boards of both United and Oxford, as well as to the shareholders of both companies. Applicant's expert additionally testified that, consistent with other managed care merger transactions, the post-merger consolidation should result in providers reducing their own administrative burden and expenses.

The hearing panel and Department staff believe that the reported efficiencies appear reasonable and achievable. MSNJ has provided no information from which it may be reasonably concluded that such efficiencies will not occur. Accordingly, the hearing panel and Department staff believe that the proposed acquisition should result in efficiencies such that the proposed acquisition should not be disapproved.

Regarding the monopsonistic impact of the merger on providers in the State, the Department's concern regarding this merger and its effects on competition relate to the transaction's probable impact on subscribers and policyholders of the combined firm, as well as the impact upon consumers of health insurance in the State generally. Moreover, N.J.S.A. 52:17B-196, enacted on January 8, 2002, authorizes independent physicians and dentists licensed in this State to jointly negotiate and enter into contractual arrangements with carriers on non-fee-related matters affecting patient care, fees, and fee-related matters. The MSNJ testified that while this law has been enacted, it has not been fully implemented and will expire in 2008. The State Attorney General has, however, developed proposed regulations implementing this law that will appear in the August 2, 2004 New Jersey Register. Once adopted, New Jersey physicians' enhanced bargaining power may enable them to negotiate more favorable employment contracts with HMOs and other health carriers.

Based on the foregoing, the hearing panel and Department staff do not believe that the proposed transaction should be disapproved. It should be noted that in response to MSNJ's concerns, the Department could take two separate actions: First, the Department could disapprove the proposed acquisition. As noted above, the Department does not believe that the proposed acquisition should be disapproved based on a review of the relevant statutory criteria set forth in N.J.S.A. 17:27A-4.1. Second, the Department could impose a condition by which Oxford or United would be required to reduce their respective market

shares in certain counties by nonrenewing a portion of the current employers and subscribers. The hearing panel and Department staff do not believe that this would be appropriate or feasible. Such action would disrupt the provision of health services to covered persons who utilize the services of United or Oxford. In addition, it is highly probable that those employers or subscribers nonrenewed would seek alternative coverage from other HMOs or health insurers that already have significant market shares in the relevant geographic area exceeding those of United and Oxford combined, thereby further increasing those competitors' market shares and resulting in further concentration of the market.

Third, it does not appear that the financial condition of the applicant will jeopardize the financial condition of Oxford. As reported in the applicable consolidated annual statement, United had shareholders' equity of approximately $5.1 billion on December 31, 2003, $4.4 billion on December 31, 2002, and $3.9 billion on December 31, 2001.

Fourth, it appears that the financial condition of the acquiring party is such that it has been solvent on a generally accepted accounting principles basis for the most recent three years immediately prior to the date of the proposed acquisition. As set forth above, United had substantial shareholders' equity for the most recent three years, indicating that it has been in a sound and viable financial condition for the relevant period. Also, United had consolidated net before-tax income of approximately $2.8 billion in 2003 and $2.1 billion in 2002.

Finally, the maximum acquisition debt of $2 billion does not exceed 50% of the $4.9 billion purchase price.

Fifth, the applicant does not propose to liquidate Oxford, sell its assets, or merge it with any other person or entity. There is nothing in the record from which it may be concluded that the proposed acquisition of Oxford would be unfair or unreasonable to Oxford's subscribers or not in the public interest. The applicant testified at the hearing that Oxford would continue to be a New Jersey domiciled HMO, and the applicant has no plans to reduce the staff of Oxford in New Jersey. United testified that there will be no change to the benefits provided by Oxford, nor will there be a change in Oxford's provider agreements. Further, as noted previously, the proposed acquisition should result in additional benefits by reducing central administrative costs, thereby costs to subscribers, and providing additional provider choice through United's provider network.

The MSNJ raised concerns about certain alleged unfair business practices engaged in by Oxford. The MSNJ also submitted documentation concerning the current status of various lawsuits involving both United and Oxford for violations of state unfair trade practices law and prompt pay laws, among other things. MSNJ states that Oxford and United are already "bad actors" who are freely engaging in wrongful conduct vis-a-vis physicians.

The hearing panel and Department staff do not believe that any evidence has been presented upon which to reasonably conclude that the proposed acquisition should be disapproved on this basis. The fact that a regulated entity

is currently engaged in litigation concerning its business practices does not in itself provide a basis upon which to disapprove an otherwise lawful transaction. Both entities are currently authorized as HMOs in this State. To the extent an HMO is found not to have complied with the law, there are appropriate remedies the Department and DHSS may utilize. It should be noted that there have been no opinions issued regarding any of the litigation cited by the MSNJ. To date, there have been no practices engaged in by Oxford that have caused the DHSS to take action related to Oxford's license to operate an HMO. While these allegations, if proven, may currently affect Oxford's and/or United's subscribers, the applicant testified regarding its commitment to improve quality of care and to significantly improve its future HMO Report Card ratings. Moreover, both the Department and DHSS will continue to vigorously pursue their respective regulatory oversight responsibilities regarding the combined firm's delivery of quality health care to the citizens of this State, and any market conduct, claims payment or other prohibited practices found to be engaged in by the combined firm will be appropriately addressed consistent with applicable statutory and regulatory law.

Sixth, there is nothing in the record from which it may be concluded that the competence, experience and integrity of the persons who would control the operations of Oxford are such that it would not be in the interest of the subscribers and of the public to permit the acquisition of control. Following consummation of the merger, Oxford's existing board of directors will be

replaced, while certain of its executive officers will remain. The individuals who will become the post-merger directors and executive officers of Oxford LLC bring with them years of experience and competence in the health insurance industry and management of HMOs. Moreover, the applicant's board of directors and executive officers will not change following consummation of the merger.

Seventh, there is nothing in the record from which it may be concluded that the acquisition is likely to be hazardous or prejudicial to the insurance buying public for the reasons substantially set forth above.

Recommendation

Based on the foregoing analysis indicating that none of the seven disqualifying factors set forth in N.J.S.A. 17:27A-2d(1) is present, the hearing panel and Department staff recommend that the proposed acquisition be approved.

Upon a thorough review of the foregoing, I concur with the findings, analysis and recommendations of the hearing panel and Department staff. I therefore recommend that the proposed acquisition be approved.

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Date Bonnie E. Bajor
Hearing Officer

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