

ANTITRUST & MARKETS

The Merger Math

Federal antitrust treats Hawaii as one market. In reality, each island is its own monopsony. A pending health-system consolidation and the federal Protecting Primary Care Act are on a collision course.

By **DAVID ISEI**

Founder, Hawaii Health Intelligence Platform
Executive Director, Hawaii Healthcare Task Force

Antitrust law in the United States runs on a single number: the Herfindahl-Hirschman Index, or HHI. Sum the squares of each firm's market share, and a market above 2,500 is considered 'highly concentrated.' Above 1,800 it is 'moderately concentrated.' Below 1,500 it is, in the comfortable language of the Department of Justice and the Federal Trade Commission, 'unconcentrated.'

Hawaii's commercial health insurance market, treated as one market, has an HHI well north of 5,000. Treated as six island-level markets, several of those islands have HHIs that effectively round to 10,000, the mathematical maximum, the formal definition of monopoly. The federal regulators who police mergers and consolidations have, for decades, used the first number. The people who actually receive care live inside the second.

HOW THE GEOGRAPHY BREAKS THE MODEL

Standard antitrust analysis assumes that buyers can substitute between sellers. If your local hospital raises prices, you drive to the next one. If your local insurer narrows its network, you switch carriers. That assumption, reasonable in Phoenix or Pittsburgh, is geographically false in Hawaii.

A patient on Lanai cannot 'substitute' to a hospital on Oahu without an inter-island flight. A primary-care physician on Molokai who loses an in-network contract with the dominant payer cannot meaningfully replace that revenue from another insurer because the dominant payer is, in practical terms, the entire commercial market. Hawaii's payer landscape, dominated by HMSA

and Kaiser Permanente Hawaii, has Med-QUEST plans (AlohaCare, HMSA QUEST Integration, Kaiser, Ohana, UnitedHealthcare Community Plan) layered on top, but the choice set on any given island is narrower than the statewide aggregate suggests.

Provider-side concentration follows the same pattern. On Hawaii Island, one hospital system dominates inpatient capacity. On Maui, two systems split the market with no meaningful third option. On the smallest neighbor islands, there is one critical access hospital and a federally qualified health center. That is the entire market. There is nothing left to consolidate, because there was never a competitive market to consolidate from.

THE PENDING MERGER

Against that backdrop, a major Hawaii health system consolidation is currently under review. The transaction details are working their way through state regulatory processes at the Department of Commerce and Consumer Affairs (DCCA) Insurance Division and, where applicable, federal antitrust review. The right framework for reviewing it is not the statewide HHI. It is the island-by-island HHI, paired with three specific tests.

First, what is the post-merger physician headcount, by specialty, on each affected island? Second, what is the post-merger network adequacy ratio against CMS time-and-distance standards on each island? Third, what is the post-merger negotiating leverage for independent primary-care physicians and small group practices, who now sign contracts with the consolidated entity as a

take-it-or-leave-it counterparty?

Those are not exotic questions. They are the standard questions federal antitrust would ask in any mainland market. They have to be asked here, by island, because that is the geography in which the consequences will actually be felt.

THE FEDERAL COLLISION

While the merger moves through state review, Congress is moving on a parallel track. The Protecting Primary Care Act, introduced with bipartisan support, would create new federal protections for independent primary-care practices in concentrated markets, including limits on certain payer contracting practices and reporting requirements for downstream effects of vertical integration between insurers and providers.

If both moves land, a major Hawaii consolidation could be approved at the state level even as new federal law begins constraining the post-merger entity's contracting behavior. That is not a hypothetical risk. It is the predictable outcome of a state regulator using one analytical framework while a federal statute begins enforcing a different one.

WHAT GOOD REVIEW LOOKS LIKE

There is a better way, and it does not require new federal authority. It requires DCCA to do four things in any major Hawaii healthcare merger review going forward.

One: publish the island-level HHI calculation, both pre- and post-merger, alongside the statewide number. Two: require the merging parties to file an island-level network adequacy attestation against CMS time-and-distance standards, with the state's right to verify. Three: require disclosure of every contract clause that affects independent primary-care practices, including most-favored-nation provisions, anti-tiering language, and any practice-acquisition rights of first refusal. Four: build in a post-merger review at 24 and 48 months, with the state retaining authority to require divestiture if commitments are not met.

WHY THIS MATTERS BEYOND HAWAII

Hawaii is an unusually clean test case for a problem that exists in every state with rural geography: federal antitrust frameworks, designed for continental markets, systematically miss concentration in places where geography itself is the barrier to substitution. Alaska has

it. The Mountain West has it. Northern New England has it. What Hawaii has, that the others do not, is that the geography is unambiguous. Ocean is not a debatable definition of market separation.

If federal regulators and Congress can get the framework right for Hawaii, they will have built the template for every other place where a 'market' on a federal map is, on the ground, a series of isolated monopolies. If they cannot, the consolidation now under review here will be the first of many, in many states, that pass federal scrutiny on the way in and create access problems that no one is empowered to fix on the way out.

The merger math, done honestly, is a six-island problem. The federal framework is a one-state framework. Closing that gap is the work of the next 24 months.

Sources & Methodology

All claims in this article are drawn from public records, federal datasets, and peer-reviewed reports. Citations are listed in order of appearance.

1. U.S. Department of Justice and Federal Trade Commission, Merger Guidelines, December 2023. <https://www.justice.gov/atr/2023-merger-guidelines>
2. U.S. Department of Justice, Herfindahl-Hirschman Index: methodology and thresholds. <https://www.justice.gov/atr/herfindahl-hirschman-index>
3. American Medical Association, Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2024 update (Hawaii market concentration data). <https://www.ama-assn.org/health-care-advocacy/competition-health-insurance>
4. Centers for Medicare & Medicaid Services, Medical Loss Ratio (MLR) Public Use Files, Hawaii issuer-level filings, most recent reporting year. <https://www.cms.gov/marketplace/resources/data/medical-loss-ratio>
5. Hawaii Department of Commerce and Consumer Affairs (DCCA), Insurance Division: rate filings, network adequacy filings, and Form A change-of-control filings. <https://cca.hawaii.gov/ins>
6. Hawaii Department of Human Services, Med-QUEST: managed care plan enrollment and contract documents. <https://medquest.hawaii.gov>
7. Centers for Medicare & Medicaid Services, Medicare Advantage and Part D Contract Year 2024 Final Rule, network adequacy time-and-distance standards (42 CFR 422.116).
8. Becker's Hospital Review, primary-care physician shortage rankings by state, 2024. <https://www.beckershospitalreview.com>
9. Federal Trade Commission, Policy Perspectives: Vertical Integration in Health Care, staff report, 2024. <https://www.ftc.gov>
10. Congressional Research Service, Health Care Provider Consolidation: Trends and Federal Policy Responses, R47692, 2024. <https://crsreports.congress.gov>
11. Protecting Primary Care Act, 119th Congress, bill text and committee reports. <https://www.congress.gov>
12. Hawaii State Health Planning and Development Agency, Health Services and Facilities Plan: hospital and inpatient capacity by island, 2024.
13. Hawaii Health Intelligence Platform (HHIP), Network Adequacy Monitor and Insurer Financial Intelligence module, island-level HHI calculations, April 2026.

Methodology note: Figures cited are the most recent publicly available at time of writing. The author is the founder of the Hawaii Health Intelligence Platform (HHIP), which aggregates and triangulates these sources for statewide healthcare policy analysis.