

March 11, 2016

Attorney General Pam Bondi  
Office of Attorney General  
State of Florida  
The Capitol PL-01  
Tallahassee, FL 32399-1050

Re: Pending Merger of Aetna with Humana

Dear Attorney General Bondi:

On behalf of the American Medical Association (AMA), Florida Medical Association (FMA) and the Florida Osteopathic Medical Association (FOMA), and our respective physician and student members, we are writing to express our thoughts and serious concerns regarding the Florida Office of Insurance Regulation (OIR) Report and Consent Order issued in its review and approval, subject to certain remedies, of the Aetna/Humana merger. We think that the OIR's findings on market concentration and increases in concentration caused by the merger are largely helpful and can inform your own investigation, although the OIR erred in finding that Medicare Advantage (MA) is not a relevant product market. Unfortunately, in shaping its remedies, the OIR erroneously deferred to the role of regulation in health insurance as a substitute for lost competition. Accordingly, we respectfully request that your office protect competition by blocking the merger.

The OIR determined "that the majority of geographic and product markets affected by the proposed acquisition would be characterized as either moderately or highly concentrated before consideration of the proposed acquisition."<sup>1</sup> It also found that in numerous markets, the merger would increase market concentrations by amounts that under the 2010 Federal Trade Commission and U.S. Department of Justice (DOJ) Horizontal Merger Guidelines (Horizontal Merger Guidelines) would be either presumed likely to enhance market power or potentially raise significant competitive concerns, particularly in more populous regions.

However, the OIR refused to block the merger, substituting an inadequate conduct remedy that it deemed "necessary" to ameliorate the increases in market concentration.<sup>2</sup> Merely a weak remedy was required, the OIR reasoned, because of the role of state and federal regulation in health insurance. Specifically, Medical Loss Ratio (MLR) requirements "effectively limit" the ability of the merged insurer to exercise market power.<sup>3</sup> Similarly, the OIR found that state and federal staffing requirements for both HMOs and

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<sup>1</sup> The OIR of Insurance Regulation, Report on the Review of Aetna Inc.'s Acquisition of Humana and Affiliates (February 12, 2016) at 3. (Report) (Exhibit 1)

<sup>2</sup> The OIR of Insurance Regulation Consent Order in the matter of the Indirect Acquisition of Human Health Insurance Company of Florida, et al. by Aetna Inc. (February 15, 2016) at 8. (Consent Order) (Exhibit 2)

<sup>3</sup> Report at 20.

exclusive provider organizations as well as network adequacy requirements limit the merged entity's ability to exercise monopsony power in the purchase of physician services.<sup>4</sup> Finally, the OIR erroneously concluded that MA is not a relevant product market because the federal government's traditional Medicare (TM) program is in "direct competition" with MA.<sup>5</sup> Moreover, "regulatory changes to Medicare...are likely to create additional competition in the near future."<sup>6</sup>

None of the regulations or role of the federal government in Medicare cited by the OIR mitigate concerns over the anticompetitive consequences of the merger in health insurance and physician markets and the resulting harm to consumers. Fortunately, the order recites that any approval granted by the order cannot be acted upon until the U.S. Department of Justice and Florida Office of the Attorney General conclude their independent investigations of the proposed transaction under the standards applicable to their respective reviews.<sup>7</sup>

#### THE OIR FINDINGS CORROBORATE AMA-FMA-FOMA's OBSERVATIONS OF THE MERGER'S SUBSTANTIAL ANTICOMPETITIVE EFFECTS

The OIR's analysis of the competitive effects of the proposed Aetna/Humana merger within Florida metropolitan statistical areas (MSAs) agrees with AMA-FMA-FOMA public comments: that the merger would be presumed likely, under the Horizontal Merger Guidelines, to enhance market power in commercial health insurance within numerous metropolitan statistical areas.<sup>8</sup> Also, to use the language of the OIR, the "impact generally is more noticeable in the more populous regions."<sup>9</sup> For example, in Miami-Fort Lauderdale-Pompano Beach and in Tampa-St. Petersburg-Clearwater, each and every segment of the commercial market - small group, medium group, large group, and individual - as shown in OIR's Table 4<sup>10</sup> are highly concentrated. Moreover, the increase in concentration caused by the merger as also shown in OIR's Table 4 exceeds the threshold of "presumed likely to enhance market power" under the Horizontal Merger Guidelines.<sup>11</sup>

#### *Commercial Markets*

In OIR's own words, here is a summary of the findings:

- For the small group market, "19 out of the 20 defined MSAs are characterized as highly concentrated prior to the merger. Following the proposed merger, based on the data, the calculations show all 20 defined MSAs as highly concentrated."<sup>12</sup>

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<sup>4</sup> Id at 20.

<sup>5</sup> Report at 15.

<sup>6</sup> Report at 19.

<sup>7</sup> Report at 13.

<sup>8</sup> Statement of the American Medical Association, Florida Medical Association Inc. and the Florida Osteopathic Medical Association to the Office of Insurance Regulation, Florida Department of Financial Services regarding Aetna Application for the Proposed Acquisition of Humana (December 17, 2015) (AMA-FMA-FOMA Statement) (Exhibit 3) pp. 3-7 with Report at 14-15, including Table 4.

<sup>9</sup> Report at page 3.

<sup>10</sup> Table 4, Report at 14.

<sup>11</sup> Id.

<sup>12</sup> Report at 14.

- “For the medium group market, all 20 defined MSAs are measured as highly concentrated before the proposed merger, and remain so afterward with no substantial increases in concentration beyond what was already evident.” In making this statement, the OIR overlooks the increase of more than 200 points in the post-merger Herfendahl-Hirschman Index (HHI) of market concentration occurring in Miami-Fort Lauderdale-Pompano Beach and in Tampa-St. Petersburg-Clearwater reported in its Table 4 and that renders the merger presumed likely to enhance market power in those markets under the Horizontal Merger Guidelines.<sup>13</sup>
- “For the large group market, 17 of the 20 defined MSAs were measured as highly concentrated prior to the merger. Following the proposed merger, the analysis indicates 19 MSAs are highly concentrated, with substantial increases in concentration in the Tampa-St. Petersburg-Clearwater and Miami-Fort Lauderdale-Pompano Beach MSAs.”<sup>14</sup>
- “In the individual market, every MSA had a measured HHI that would be considered highly concentrated [meaning HHI more than 2500], though the range varied from 2645 in the Miami-Fort Lauderdale-Pompano Beach MSA to 9119 in the Panama City-Lynnhaven-Panama City Beach MSA. When calculated on a post-merger basis, the most significant increases in market concentration were found in the Palm Bay-Melbourne-Titusville, Lakeland-Winter Haven, and Miami-Fort Lauderdale-Pompano Beach MSAs.”<sup>15</sup>

#### Market Shares Have Been Durable Over Time

While the OIR acknowledges that “more weight is given to market concentration analysis when market shares have been stable over time.”<sup>16</sup> OIR omits applying this consideration to its analysis. The AMA has studied this important issue. The AMA’s analysis shows that in the numerous large MSAs where the merger would be anticompetitive in commercial markets, the market shares, ranking of market leaders, and number of competitors, have been durable and little changed from 2010 through 2013, the most recent timeframe for which the AMA has data.<sup>17</sup>

#### *Medicare Advantage*

The competitive ramifications of the Aetna/Humana merger within MA markets appear to be even more troubling than in the commercial health insurance markets studied by AMA and OIR.<sup>18</sup> Within MA MSA markets, the OIR finds HHIs in five MSAs to be moderately concentrated, *and the remainder were in the highly concentrated range*. Moreover, “when the post-merger HHIs were calculated, only one MSA

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<sup>13</sup> Report at 15.

<sup>14</sup> Id.

<sup>15</sup> Id.

<sup>16</sup> Id at 6.

<sup>17</sup> AMA-FMA-FOMA Statement at 8.

<sup>18</sup> In a statewide private MA market, the OIR reports “the moderately competitive market observed prior to the proposed merger, moved slightly into the highly concentrated range and the combined Aetna/Humana entity has a market share of 45.6%.”

continued to be considered moderately concentrated. The remaining four that were previously moderately concentrated migrated into the highly concentrated range, in most cases substantially so.”<sup>19</sup>

Faced with this structural damage to competition in MA, the OIR devotes many pages to its conclusion that MA competes directly with TM. Once TM and MA are seen to be in one Medicare market, the OIR argues, “the impact of the proposed acquisition affects the highly concentrated Medicare market by only a minimal amount.”<sup>20</sup>

While the damage to the commercial market provides an ample reason for blocking the merger, we now turn to a discussion of why MA and TM are not in the same product market such that the competitive harm shown to be occurring in the MA market is yet one more reason for blocking the merger.

#### Medicare Advantage Is A Relevant Product Market

The OIR erroneously accepted Aetna’s argument that MA is not a relevant product market because MA consumers have the option of switching between MA and TM operated by the government. In OIR’s view, there is a larger relevant market composed of MA and TM wherein Aetna faces the government as a competitor.

Aetna and the OIR have mischaracterized the federal government’s role. The federal government is not an Aetna competitor attempting to compete for Medicare business. Instead the government is a purchaser procuring competitive bids from private health insurers competing to offer MA plans to Medicare beneficiaries.<sup>21</sup> Congress’s goal in establishing the MA program was “that vigorous competition among private MA insurers...would lead those insurers to offer seniors a wider array of health insurance choices and richer and more affordable benefits than TM does, and be more responsive to seniors.”<sup>22</sup> In the event Aetna were to acquire Humana, and competition for the government contract and MA beneficiaries were lessened, the government would actually be harmed, not advantaged, as would be the case if it were a competitor, by the higher prices and/or poorer service offered by a combined Aetna/Humana in MA.<sup>23</sup> Accordingly, once the government is understood as a purchaser, there is a relevant MA market in which the proposed acquisition clearly lessens competition substantially.

If for the sake of argument the government could plausibly be characterized as a competitor to health insurers offering MA, then whether in a given case the government’s TM and the private insurer’s MA plans are separate products would require a demand substitutability test, a well-established way of

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<sup>19</sup> Report at 15.

<sup>20</sup> Consent Order at ¶ 19

<sup>21</sup> For an explanation of the competitive bidding process See Song, Landrum and Chernew, “Competitive Bidding and Medicare Advantage: Effect of Benchmark Changes Unplanned Bids”, Journal of Health Economics 32 (2013) 1301-1312. <http://www.ncbi.nlm.nih.gov/pubmed/24308881>

<sup>22</sup> See, United States v. Humana and Arcadian Management, No. 12-cv-00464 (D.D.C. Mar. 27, 2012) (complaint) (avail. at <http://www.justice.gov/atr/case-document/file/499076/download>)

<sup>23</sup> A Center for American Progress Study has concluded that Medicare program spending would increase as a result of the merger. Spiro, Calsyn, O’Toole, “Bigger is not Better: Proposed Insurer Mergers are Likely to Harm Consumers and Taxpayers,” Center for American Progress (Jan. 21, 2016)

determining whether markets are separate.<sup>24</sup> The test asks whether customers have an ability and willingness to substitute away from one product to another in response to a small but significant and non-transitory increase in the quality adjusted price of the product.

When applying the demand substitutability test to MA in merger cases, the DOJ has concluded that seniors are not likely to switch away from MA plans to TM in sufficient numbers to make an anticompetitive price increase or reduction in quality unprofitable to a MA insurer.<sup>25</sup> In consent decrees that the DOJ has entered into with Humana and Arcadian Management and with UnitedHealth Group and Sierra Health Services (Consent Decrees) rightly observe that TM is not an adequate substitute for MA because MA plans offer substantially richer benefits at lower costs than TM,<sup>26</sup> including lower copayments, lower coinsurance, caps on total yearly out-of-pocket costs, prescription drug coverage, and supplemental benefits that TM does not cover, such as dental and vision coverage, and health club memberships. Even the OIR concedes that MA offers a superior “value proposition.”<sup>27</sup> Moreover, in MA plans, seniors can receive a single plan covering a variety of benefits that seniors in TM must assemble themselves. The combination of richer benefits and one stop shopping accounts for the strong preference by many seniors for MA plans. Consequently, the closest competition to one MA insurer’s plan is another insurer’s MA plan and the presence of many competing MA insurers is what keeps quality and price competitive. This conclusion is buttressed by a recent study finding that when Humana offers a Medicare Advantage plan in the same county as Aetna, Aetna’s premium is lower than in counties where Humana does not offer a plan.<sup>28</sup>

The OIR neither distinguishes the DOJ consent decree findings that MA is a separate product market nor cites any case law or scholarship concluding that MA is not a product market. Instead, the OIR references a study finding that annually “approximately 5% switch into MA from TM.”<sup>29</sup> Ironically rather than support the contention that MA and TM patients have an ability and willingness to substitute away from one product to another in response to a small but significant and non-transitory increase in the quality adjusted price of the product, the cited study’s authors refer to an “MA market” and conclude that the observed 5% switching number is Troublesomely low.<sup>30</sup>

The OIR cites data supplied by Thomas McCarthy, PhD, Aetna’s expert at the hearing, indicating that annually 21% -25 % of persons terminating Aetna or Humana’s MA turn to TM.<sup>31</sup> If accurate, this Aetna/Humana reported rate of switching from MA to TM is many times the national rate reported in a

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<sup>24</sup> See Horizontal Merger Guidelines, Section 4.

<sup>25</sup> United States v. Humana and Arcadian Management, No. 12-cv-00464 (D.D.C. Mar. 27, 2012) (complaint ¶¶ 20-21) (avail. at <http://www.justice.gov/atr/case-document/file/499076/download>); United States v. UnitedHealth Grp. Inc. & Sierra Health Servs., Inc., No. 08-cv-00322 (D.D.C. Feb. 25, 2008) (complaint ¶¶ 15-18) (avail. at <http://www.justice.gov/atr/case-document/file/514126/download>). Paragraph 2

<sup>26</sup> Id.

<sup>27</sup> Consent Order at paragraph 20(c).

<sup>28</sup> Spiro et al, *supra* n. 23

<sup>29</sup> Report at 18, citing Sinaiko, Afendulis, & Frank, Enrollment in Medicare Advantage Plans in Miami-Dade County: Evidence of Status Quo Bias?, 50 Inquiry 202 (2013), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4108259>

<sup>30</sup> Sinaiko, Afendulis, & Frank, Enrollment in Medicare Advantage Plans in Miami-Dade County: Evidence of Status Quo Bias?, 50 Inquiry 202 (2013), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4108259>

<sup>31</sup> Report at 18.

recent peer reviewed article.<sup>32</sup> The authors of that article found that nationally between 2006 and 2011 on average annually “[f]ewer than 5% of TM beneficiaries switched to MA and a similar percentage of MA enrollees switch to TM. These results suggest that initial coverage decisions have long-lasting effects.”<sup>33</sup>

We do not know from Dr. McCarthy’s testimony why patients left the Aetna/Humana MA offerings and turned to TM at a rate roughly five times the national average. At the extreme, the patients leaving Aetna and opting for TM may have been forced to turn to TM by for example, Aetna’s terminating service. Moreover, Dr. McCarthy does not explain why the overwhelming portion of Aetna’s MA enrollees, apparently stay with MA. One explanation is that TM is not an adequate substitute for MA, absent extreme circumstances that may account for those who switch from Aetna/Humana to TM.

The OIR advances a final speculative argument under the heading of “The future of Medicare.” It claims that there will be future regulatory changes that will narrow the differences between MA and TM that will “likely” “create additional competition” between them “in the near future.”<sup>34</sup> Predicting the future of Medicare should never be the basis of approving a merger. In any event, the government’s interest will continue to be that of a consumer on behalf of Medicare beneficiaries promoting choice and innovation through a MA program that, as compared with TM, offers lower costs and richer benefits as a trade-off for a more limited healthcare provider network than TM.<sup>35</sup> Consequently, MA is, and will likely remain into the foreseeable future, a product market that is separate and distinct from TM.

#### THE OIR RELIES ENTIRELY ON WHOLLY INADEQUATE FORMS OF ADMINISTRATIVE REGULATION FOR PROTECTING THE QUALITY AND QUANTITY OF PHYSICIAN SERVICES

The AMA-FMA-FOMA advised the OIR that consumers do best when there is a competitive market for purchasing physician services.<sup>36</sup> The AMA-FMA-FOMA also asked that the OIR not approve Aetna’s acquisition of Humana because it would eviscerate physician ability to contract with alternative insurers in the face of unfavorable contract terms and would.<sup>37</sup>

- Result in weaker provider networks for consumers, reducing patient access to physicians and effectively curtailing their services;
- Hinder physician ability to invest in new equipment, technology, training, staff and other practice infrastructure that could improve access to, and quality of, patient care—investment critical for enabling physicians to successfully transition into new value-based payment and delivery models;
- Force physicians to spend less time with patients to meet practice expenses;

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<sup>32</sup> Gretchen A. Jacobson, Patricia Neuman, Anthony Damico, “At Least Half Of New Medicare Advantage Enrollees Had Switched From Traditional Medicare During 2006–11,” 34 *Health Affairs* (Millwood) 48, 51 (Jan. 2015), available at: <http://content.healthaffairs.org/content/34/1/48.full.pdf>.

<sup>33</sup> Id at 1.

<sup>34</sup> Consent Order paragraph 20(d).

<sup>35</sup> See paragraph 17 of Consent Order in *United States v. Humana and Arcadian Management Services*. *Supra*.

<sup>36</sup> AMA Statement at 14.

<sup>37</sup> Id at 14-16.

- Pressure physicians not to engage in aggressive patient advocacy, a crucial safeguard of patient care; and
- Motivate physicians to retire early or seek opportunities outside of medicine that are more rewarding, financially or otherwise.

All of the above anticompetitive effects in Florida physician markets were identified as likely to occur by very large percentages of Florida physicians responding to a 2016 FMA survey:<sup>38</sup>

- 85% of respondents believed that the Aetna/Humana merger would be very or somewhat likely to lead to narrower physician networks which will in turn reduce patient access to care, with 73% reporting that they will be very or somewhat likely pressured not to engage in aggressive patient advocacy as a result of the mergers;
- 90% of respondents believed that the Aetna/Humana merger would be very or somewhat likely to decrease reimbursement rates for physicians such that there would be a reduction in the quality and quantity of the services that physicians are able to offer their patients; and
- If Aetna and Humana merged and the reporting physicians did not continue to have a contract with the merged health plan, the following consequences were reported:
  - 9% of responding physicians would retire from active practice;
  - 9% would need to close their practice;
  - 5% would move their practice to a more competitive reimbursement market;
  - 27% would cut investments in practice infrastructure;
  - 34% would cut or reduce staff salaries;
  - 27% would have to spend less time with patients; and
  - 18% would cut quality initiatives or patient services.

The OIR acknowledged the presence of monopsony power acquired in the merger while at the same time erroneously speculating that regulation supplies a cure, albeit partial: “[n]etwork adequacy requirements limit, to some extent, the ability to exercise monopsony power, independent of concentration.”<sup>39</sup> Moreover, the OIR found that “monopsony power is limited by state and federal laws requiring health maintenance organizations and exclusive provider organizations to have a minimum number of healthcare providers and facilities available in a specific market.”<sup>40</sup> The OIR does not, and cannot, explain how provider staffing regulations imposed on exclusive provider organizations and HMOs would cure the anticompetitive effects of physicians retiring from practice, cutting staff or spending less time with patients to meet practice expenses, and other harms to the physician market. Provider organizations are victims, not the solution, to this monopsony injury that would be caused by the merger.

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<sup>38</sup>This survey was administered to members of the Florida Medical Association. In total, 126 physicians completed the survey, although specific questions only polled a subset of physicians depending on whether they were decision makers in the practice.

<sup>39</sup>Report at 3. See also Report at 20.

<sup>40</sup>Report at 20.

Similarly, network adequacy requirements/standards are no panacea for the weaker provider networks likely to result from the merger. Generally speaking, the standards focus simply on vague notions of whether “enough” providers and facilities are included in the network. They address “adequacy” as a floor and not as prescription for optimal physician availability. Moreover, Florida’s network adequacy requirements lack objective measurements of network adequacy and do not address the issue of providers changing their minds on whether to accept new patients, common limitations in network adequacy regulation.<sup>41</sup> Indeed, the standards are wholly inadequate even for the task of providing a floor protecting consumers. Thirty-seven percent of respondents to the Florida Medical Association survey said they had difficulty finding available in-network physicians who accepted new patients for referrals with Aetna and Humana; while 59% encountered formulary limitations which prevented a patient’s optimal treatment.

Also in Florida, as elsewhere, the state regulations do not address whether in-network providers are high-quality.<sup>42</sup> Consequently, the regulations allow health plans to cherry pick physicians based on costs (not quality) in order to have the lowest cost patients. Therefore, rather than increasingly relying on network adequacy requirements, regulators need to foster health insurer competition promising broader high quality networks responsive to patients’ access needs.

Importantly, network standards cannot cure the fundamental problem requiring that the merger be blocked – that health insurer monopsonists typically are also monopolists. Facing little if any competition in the market for health plans, the merged entity would lack the incentive to refrain from imposing upon physicians take it or leave it contracts resulting in anticompetitive reimbursement levels that hinder physician investment in practice infrastructure, force them to spend less time with patients to meet practice expenses or motivate them to leave the physician workplace. No amount of speculation about the future coverage of network adequacy requirements<sup>43</sup> – a program not even intended to address the most profound monopsony injuries to the physician marketplace – can justify the merger.

## MEDICAL LOSS RATIO

The OIR relies on the notion that Florida and federal MLR requirements compensate for competition lost as a result of the merger. While we and others have exhaustively explained MLR’s myriad of limitations in protecting consumers from anticompetitive premium increases,<sup>44</sup> the OIR offers no counterargument. Instead it simply declares:

[f]or several decades Florida law, and more recently federal laws, have included MLR requirements. For the markets considered in this report, the MLRs range from 80% to 85%.

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<sup>41</sup> See Network Adequacy and Exchanges, The National Committee for Quality Assurance, (2013)

<sup>42</sup> *Id.*

<sup>43</sup> See Report at page 20

<sup>44</sup> James L. Madara, MD, Executive Vice President, American Medical Association letter to the Hon. William Baer, Assistant Attorney General, United States Department of Justice, Antitrust Division, (November 11, 2015) at page 12 (Exhibit 4); Melinda Hatton, Senior Vice President and General Counsel, American Hospital Association letter to Ted Nichel, Wisconsin Insurance Commissioner and Katherine Wade, Connecticut Insurance Commissioner (February 23, 2016) (Exhibit 5); Leemore Dafny, “Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?”, Testimony before the Senate Committee on the Judiciary, (September 22, 2015) (Exhibit6), at 10.

These requirements guarantee that consumers will receive eighty to eighty-five cents in healthcare services for every dollar of premium paid and they effectively limit any entity's ability to exercise market power, independent of concentration.<sup>45</sup>

In relying on MLR to protect consumers from an exercise of market power, the OIR stays true to its theme running through its entire analysis of this merger – that regulations, intended as a floor on the value of health insurance products, can substitute for competition.

In the case of the Affordable Care Act's MLR standard, even if a majority of privately-insured enrollees were affected by the MLR (which they are not),<sup>46</sup> and it addressed the level of premium increases (and not solely the percentage used for claims and quality activities), there is no basis for the OIR to assume that the floors are higher than what a competitive market would supply. Industry aggregate MLR generally have exceeded the required percentages.<sup>47</sup> Also, Medicare administrative expenses for 2014 were merely 1.4% of total expenditures, suggesting that the MLR value floor should not be aspirational and should not be treated as displacing competition.

Finally, MLR requirements do not address non-price dimensions of health insurer competition. Only competition will force insurers to enhance customer service, improve provider networks, pay bills accurately and on time, and develop and implement innovative ways to improve quality while lowering costs.

#### ABSENCE OF EFFICIENCIES

The AMA-FMA-FOMA has previously explained that Aetna's merger efficiency claims are unsupported and speculative.<sup>48</sup> Tellingly, neither the OIR's Consent Order nor its Report even mention a single claimed efficiency as a justification for approving the merger. The only mention paid to Aetna's claimed efficiencies is within the remedy portion of the Consent Order reciting that the health insurers have "represented" that "certain efficiencies will be achieved as a result of the proposed transaction."<sup>49</sup> Without identifying the efficiencies, the Order merely requires the merged entity to annually submit for the first three years following the merger, documentation detailing the realization of estimated efficiencies.<sup>50</sup> The Order contains no benchmarks for measuring expected efficiencies, nor remedies for failure to obtain them. The vagueness and lack of enforcement teeth in the Order's "efficiencies" reporting requirement is a testament to how efficiencies played no real role in justifying the merger.

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<sup>45</sup> Report at 20.

<sup>46</sup> Dafny testimony, *supra* n.44 at 14 ("More than half of privately-insured enrollees are in self-insured plans, and the minimum MLR do not pertain to these plans.")

<sup>47</sup> <http://inq.sagepub.com/content/50/1/9.full.pdf>

<sup>48</sup> See AMA Statement to the Office of Insurance Regulation at 16-18.

<sup>49</sup> Consent Order at paragraph 25.

<sup>50</sup> Consent Order at paragraph 25.

## REMEDY

The AMA-FMA-FOMA have advocated that the merger be blocked. The OIR's Consent Order, by contrast and as explained above, ineffectually requires the merged entity to report on unidentified efficiencies. It also requires Aetna to "develop a plan" to enter into Florida individual health insurance exchanges in five counties not currently covered. Nowhere does the Consent Order explain how Aetna/Humana entering into new markets would remedy the substantial lessening of competition in the numerous populous markets identified by AMA and the OIR's own study. Moreover, the agreement to enter these underserved markets is as a practical matter nonbinding and illusory. The merged entity only needs to enter if it finds the move practical and profitable, specifically that it can "secure a competitive position based upon adequate premium rates; enter into satisfactory contracts with a sufficient number of providers to meet network adequacy standards in each county reviewed; and other competitive factors some of which may be related to federal exchange policies."<sup>51</sup>

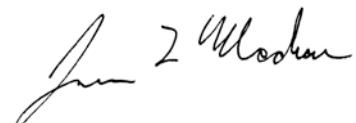
## CONCLUSION

Apart from its erroneous finding that MA is not a relevant product market, the OIR should be commended for thoroughly investigating and determining the extensive anticompetitive market structural damage that would be caused by Aetna's proposed merger with Humana. The OIR also wisely rejected divestiture as a remedy too disruptive to existing physician-patient relationships.

However the OIR appears to have been captured by Aetna's faulty arguments that existing state and federal regulation - MLR and staffing requirements - mostly solve the competitive concerns and justify very limited remedies that are largely illusory. Both forms of regulation have only partial applications to the value and quality concerns raised by the merger. They also are designed as performance floors, and they are not intended to displace competition and the additional benefits that blocking this merger would achieve.

We, therefore, respectfully request that you block the merger to preserve competition and protect Florida patients and other consumers.

Sincerely,



James L. Madara, MD

cc: Florida Medical Association  
Florida Osteopathic Medical Association

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<sup>51</sup> Consent Order at paragraph 24(b)

## **Table of Exhibits for AMA Letter to Florida AG Dated March 7, 2016**

Exhibit 1: Florida Office of Insurance Regulation Report on the Review of Aetna Inc.'s Acquisition of Humana and Affiliates (February 12, 2016)

Exhibit 2: Florida Office of Insurance Regulation Consent Order in the Matter of the Indirect Acquisition of Humana Health Insurance Company of Florida et al by Aetna Inc. (February 15, 2016)

Exhibit 3: Statement of the American Medical Association, Florida Medical Association Inc. and the Florida Osteopathic Medical Association to the Office of Insurance Regulation, Florida Department of Financial Services regarding Aetna Application for the Proposed Acquisition of Humana (December 17, 2015)

Exhibit 4: James L. Madara, MD, Executive Vice President, American Medical Association letter to the Hon. William Baer, Assistant Attorney General, United States Department of Justice, Antitrust Division, (November 11, 2015)

Exhibit 5: Melinda Hatton, Senior Vice President and General Counsel, American Hospital Association letter to Ted Nichel, Wisconsin Insurance Commissioner and Katherine Wade, Connecticut Insurance Commissioner (February 23, 2016)

Exhibit 6: Leemore Dafny, "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?" Testimony before the Senate Committee on the Judiciary (September 22, 2015)

# Report on the Review of Aetna Inc.'s Acquisition of Humana and Affiliates

February 12, 2016



FLORIDA OFFICE OF  
INSURANCE REGULATION

Kevin M. McCarty, Insurance Commissioner

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## Executive Summary

The Office of Insurance Regulation (Office) is required by statute to consider the impacts on market structure and competition resulting from proposed mergers between insurance companies operating in the state. This report analyzes the potential market impact in Florida of the proposed merger between the relevant Aetna and Humana companies.

The analysis is based on well-recognized methodologies that rely on current and historical data and is used largely to consider the impact of horizontal mergers, where the entities involved in the proposed merger offer the same, or highly substitutable, products. Particular care is taken to ensure that the analysis provides an accurate and appropriate representation of Florida product and geographic markets.

The report finds:

- The majority of geographic and product markets identified would be characterized as either moderately or highly concentrated before consideration of the proposed merger.
- The impact of the merger in the markets considered is a matter of the degree to which the already existing conditions for the ability of market power to be exercised is enhanced and not where the merger would create the opportunity for the exercise of market power where it did not previously exist.
- Minimum Loss Ratio requirements effectively limit the ability to exercise market power, independent of concentration.
- Network adequacy requirements limit, to some extent, the ability to exercise monopsony power, independent of concentration.
- When using county definitions, Florida Agency for Health Care Administration (AHCA) region definitions or Metropolitan Statistical Areas (MSA) region definitions, (a Bureau of Census definition), the results are similar and show some increase in the degree of concentration that would be viewed as meaningful in some group insurance markets, relatively few individual markets and most noticeably in the Medicare Advantage markets. The impact generally is more noticeable in the more populous regions. Smaller population areas do not seem to experience any meaningful impact from the proposed merger.

- The relatively strong impact in the Medicare Advantage markets should be viewed in context. While the degree of concentration rises sharply in some regions in the private Advantage markets, it is also true that when traditional Medicare is considered, the proposed merger does little to impact the dominance of the Federal program throughout the state. This market warrants additional monitoring moving forward as it is difficult to characterize it as a stable market.
- Taken as a whole, while there may be some particular product and regional areas where additional factors and discussion, outside the scope of this analysis, is likely appropriate, overall, there is not strong evidence of an overall significant reduction in the competitive landscape of the private Florida health insurance markets resulting from this proposed merger.

## Introduction

The Office is required by statute to consider the impacts on market structure and competition resulting from proposed mergers between insurance companies operating in the state.<sup>1</sup> This report analyzes the potential market impact in Florida of the proposed merger between Aetna and Humana (including relevant subsidiary companies)<sup>2</sup>.

The analysis and conclusions presented here apply to the potential impact of this proposed merger on the Florida health insurance marketplace. While this is a national level merger, the Office has the regulatory responsibility and authority to analyze the effects of the proposed merger on activity within the state. While other states are conducting their own analysis, likely using similar measures and methodologies, the results are likely to be different, in some cases dramatically so, across the states based on the current business models and activity of the two insurance groups. As such, the results and conclusions provided in this report are not, and should not be, directly comparable to the results and findings from other states.

The core of the analysis provided here is based on well-recognized methodologies that rely on current and historical data and is used largely to consider the impact of horizontal mergers, where the entities involved in the proposed merger offer the same, or highly substitutable, products. The veracity of the analysis depends on the accurate representation of product and geographic markets.

This report recognizes that health insurance products are not generally considered close substitutes for one another, but vary considerably in terms of providers, policyholders and geographic markets. To that end, this report provides results based on careful definitions of product markets, and considers several different definitions of geographic regions.

Moreover, one product market, the Medicare market, is considered separately as this is the one market characterized by a significant public market provider (e.g. the Federal government) in addition to the private market insurers.

The focus on the competitive impact resulting from mergers is based on concerns that the mergers can have on output pricing and quantity (e.g. monopoly power) and on input pricing and quantity (e.g. monopsony power). In the health insurance markets, the concerns over the exercise of monopoly power are expressed in terms of the cost and availability of health insurance products to current and potential policyholders. Concerns regarding the exercise of monopsony power are expressed in terms of fee schedules and accessibility for physicians, hospitals, and other medical service providers.

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<sup>1</sup> For this merger application, this requirement would be subject to Sections 628.461, F.S.; 628.4615, F.S.; 636.065, F.S.; and 641.255(3), F.S.

<sup>2</sup> These companies from the Humana Group include CarePlus Health Plans, Inc. (HMO), CompBenefits Company (Pre-Paid Limited Health Service Organization), Humana Health Insurance Company of Florida, Inc. (Life & Health Insurer), and Humana Medical Plan, Inc. (HMO).

While these are valid concerns, the current regulatory and legal framework in the health insurance market is designed to address the issues, at least on some level. For policyholders, the Minimum Loss Ratio (MLR) requirement would, all else equal, tend to dampen price (premium) increases. For example, in the individual market if the MLR were to fall below 80% for an insurer, some portion of premium income is rebated back to policyholders. For providers, there is as well some protection as the laws require health maintenance organizations and exclusive provider organizations to have a minimum number of contracts in place in a specific market.

The focus of the current analysis is on the competitive impact of the proposed merger on the output portion of the market. This is consistent with the Office's regulatory responsibility regarding market stability, availability, and cost.

## **Methodology**

### ***Measurement Metrics***

Market concentration is often one useful indicator of likely competitive effects of a horizontal merger, and a key measure explicitly considered by the Department of Justice (DOJ) and other agencies. In evaluating market concentration, the typical analysis considers both the pre-merger level of market concentration and the change in concentration resulting from a merger.

Typically, more weight is given to market concentration analysis when market shares have been stable over time, especially in the face of historical changes in relative prices or costs.

The most frequently used measure of market concentration is the Herfindahl-Hirschman Index (HHI). The HHI is calculated by summing the squares of the individual firms' market shares, and thus gives proportionately greater weight to the larger market shares. When using the HHI, the analysis considers both the post-merger level of the HHI and the increase in the HHI resulting from the merger. The increase in the HHI is equal to twice the product of the market shares of the merging firms.

In addition, other metrics are frequently used to describe market concentration and competitive nature. Commonly used measures based on the market share of the 3, 4, 5 or 10 largest firms in a market are often recited. In Florida, references to four firm concentration ratios are sometimes used in regulatory considerations. These measures, however, lack the robustness necessary to consider the impact of an overall market and all of the participants in the market.

In contrast, the HHI is a more robust measure of the size of firms in relation to the overall market or industry being considered and is a broader indicator of the amount of competition among them. As a result, the HHI is an economic concept widely applied in legal challenges regarding competition law and anti-trust challenges.

The HHI in practice is defined as the sum of the squares of the market shares of the 50 largest firms (or summed over all the firms if there are fewer than 50) within an industry or defined market. The result is proportional to the average market share, weighted by market share.

To provide some context for the HHI consider two extreme examples. At one extreme, a market may consist of one firm capturing 100% of the market. The resulting HHI would be 10,000 (e.g.  $100^2$ ). At the other extreme, consider a market with 100 firms each with a 1% market share. The resulting HHI would be 100. “High” values of the HHI indicate a limited degree of competition and a high degree of market power while “low” values of the HHI indicate higher degrees of competition and a reduction in potential market power.

The determination of competitiveness in a market or industry using the HHI, then, relies on interpretation of the calculation. Standards common in practice can be found in the Horizontal Merger Guidelines published jointly by the DOJ and the Federal Trade Commission (FTC).<sup>3</sup> In these guidelines the Agencies find:

*Based on their experience, the Agencies generally classify markets into three types:*

- **Unconcentrated Markets:** HHI below 1500
- **Moderately Concentrated Markets:** HHI between 1500 and 2500
- **Highly Concentrated Markets:** HHI above 2500

*The Agencies employ the following general standards for the relevant markets they have defined:*

- **Small Change in Concentration:** Mergers involving an increase in the HHI of less than 100 points are unlikely to have adverse competitive effects and ordinarily require no further analysis.
- **Unconcentrated Markets:** Mergers resulting in unconcentrated markets are unlikely to have adverse competitive effects and ordinarily require no further analysis.
- **Moderately Concentrated Markets:** Mergers resulting in moderately concentrated markets that involve an increase in the HHI of more than 100 points potentially raise significant competitive concerns and often warrant scrutiny.
- **Highly Concentrated Markets:** Mergers resulting in highly concentrated markets that involve an increase in the HHI of between 100 points and 200 points potentially raise significant competitive concerns and often warrant scrutiny. Mergers resulting in highly concentrated markets that involve an increase in the HHI of more than 200 points will be presumed to be likely to enhance market power. The presumption may be rebutted by persuasive evidence showing that the merger is unlikely to enhance market power.

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<sup>3</sup> *Horizontal Merger Guidelines*, U.S. Department of Justice and Federal Trade Commission, Issued August 19, 2010.

Using market share data based on policy enrollment, then, the HHI in the following analysis is calculated as<sup>4</sup>:

$$H = \sum_{i=1}^N s_i^2$$

where

**H** = HHI index value,

**N** = number of firms in a particular market as defined,

**s<sub>i</sub>** = market share of firm *i* in the defined market.

While a relatively straightforward calculation, the usefulness of an HHI analysis is critically dependent on the definition of product and geographic markets chosen for analysis.

Again, the purpose of these thresholds is not to provide a rigid screen to separate competitively benign mergers from anti-competitive ones but to provide one way to identify some mergers unlikely to raise competitive concerns and some others for which it is particularly important to examine whether other competitive factors confirm, reinforce, or counteract the potentially harmful effects of increased concentration. The higher the post-merger HHI and the increase in the HHI, the greater are the potential competitive concerns and the greater is the likelihood that other information and analysis will be needed.

### **Data**

The company specific data underlying this report were obtained through the Major Medical and Medicare Advantage (MMMA) data call performed by the Office in the Fall of 2015. Data were requested at the county level from a constrained list of companies that make up roughly 95% of Florida GAP reported premiums as collected in the *Accident & Health Markets Gross Annual Premium and Enrollment Summary CY 2014* (GAP).

These data were selected for the analysis as they provided more granularity of reporting for the appropriate geographic markets than would be available from Statutory Annual Statement filings.

Traditional Medicare enrollment data were obtained from the Centers for Medicare and Medicaid Services (CMS)<sup>5</sup>.

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<sup>4</sup> For this analysis enrollment data was selected for measuring market share rather than premium data as the enrollment data is a more direct reflection of the “touch” of an insurer on the consuming public.

<sup>5</sup> <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-07-28.html>

### **Product Markets**

For the analytical purposes of this report, the assumption is made that not all “health” insurance products are substitutes for one another. Recognizing substantial differences in the marketplace, with regard to both providing insurers and policyholders, a number of product markets, e.g. lines of business, are identified<sup>6</sup>. These are:

- Large Group;
- Medium Group;
- Small Group;
- Individual;
- Other Commercial;
- Medicare and Medicare Advantage, and;
- Medicaid.

### **Geographic Markets**

There are a number of ways to segment the Florida market geographically. Much of the work done in insurance market structure in Florida for regulatory and policy purposes relies upon reporting done on a by county basis. The data could alternatively be grouped by regions as defined by the AHCA in their reporting.<sup>7</sup> Finally, The American Medical Association (AMA) uses data grouped by Metropolitan Statistical Areas (MSAs) in their reporting of health insurance and competition<sup>8</sup>.

### **Statewide Analysis by Product Line**

In the case of the Aetna/Humana merger, there are several health insurance product lines where both groups currently write business. A merger then, could potentially increase market power, as the resulting product market would, by definition, become more concentrated.

At the broadest level, the analysis begins by examining the degree of market concentration resulting from the proposed merger on a statewide basis. Table 1 below provides the estimated pre-merger and post-merger HHI values based on the reported data. The data provide several important insights. First, only in the case where the entire state is considered the geographic market and where all different lines of health insurance business are considered interchangeable (perfect or close substitutes) can a finding of a “highly competitive” market be shown, that is a market identified as being unconcentrated, prior to calculating the impact of the proposed merger. At this broad level of defined market, the impact of the proposed merger is minimal. As Table 1 shows, the measured HHI moves from 1,261 (unconcentrated) to 1,568 (just barely over the boundary between unconcentrated and moderately concentrated, again as defined by the DOJ).

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<sup>6</sup> Detailed definitions of these product lines are in Appendix 2. Several lines identified in the Appendix are not included in this analysis as either none of the companies involved are active in those lines of business (Conversion and Healthy Kids) or the Federal Government is responsible for granting access to the line of business and is thus out of the purview of the Office (Federal Employee).

<sup>7</sup> The mapping of counties into AHCA regions is included in Appendix 3.

<sup>8</sup> See Appendix 3 for MSA definitions used in this analysis.

The second insight can be found by looking at the impact of the proposed merger on the separate lines of business, recognizing that these lines are not in most cases very close substitutes for each other. The measured pre-merger HHIs suggest that, on a statewide basis, all but two of the markets can already be characterized as highly concentrated. The remaining two, Medicare Advantage and Medicaid, are moderately concentrated. This can also be seen by examining the calculated four firm concentration ratios, which show that except for the Large Group line, Medicare Advantage and Medicaid, the markets were almost entirely served by the four largest firms. Following the merger, using extant data, the Large Group market shows a significant increase in four firm concentration.

**Table 1: Statewide Herfindahl-Herschman Index (HHI) by Line**

Product Line	Current HHI	Post-Merger HHI	Increase in HHI due to Aetna/Humana	Increase in HHI due to Anthem/Cigna	Statewide Four-Firm Concentration Pre-Merger	Statewide Four-Firm Concentration Post-Merger
Small Group	2,836	3,120	284	0	93.37%	98.76%
Medium Group	3,564	3,662	98	0	97.16%	99.01%
Large Group	2,676	2,912	236	0	88.13%	97.22%
Individual	3,038	3,954	916	0	95.69%	99.01%
Other Commercial	9,519	9,519	0	0	100.00%	100.00%
Medicare Advantage	2,228	2,712	470	15	73.70%	79.63%
Medicaid	1,980	2,006	27	0	79.19%	79.19%
All Lines Combined*	1,261	1,568	274	33	62.68%	71.40%
Total Medicare	4,223	4,291	66	2		
Commercial Lines	2,570	2,992	422	0		
Public Lines	1,449	1,582	112	21		

\*Includes all lines of business as defined in the text, not just those line highlighted in the Table.

When considered post-merger, the markets that were highly concentrated prior to considering the merger of course remain so, and the Medicare Advantage line of business can be characterized as moving from being moderately concentrated to highly concentrated, although as further analysis below will show, this result may be somewhat misleading on a practical economic basis.

More specifically, using the DOJ guidelines on the change in HHI in market structure, five lines exceed the 200 threshold value considered meaningful for further consideration, beyond the scope of the type of analysis considered here. These are the Small Group insurance, Large Group insurance, Individual insurance, Medicare Advantage, as noted.

In summary, when measuring the competitive impact of the proposed merger on a statewide basis, the data suggest that the markets generally exhibit the characteristics necessary for the exercise of market power (monopoly or monopsony) currently. The proposed merger does not create the possibility where it did not previously exist, but rather exacerbates the degree, at some level, to which such activity may already exist. In five of the markets considered, the degree to which this possibility is increased is suggested to warrant further consideration as to cause, effect, or mitigating conditions.

## Regional Analysis by Product Line

In practical terms, it is also important to consider geographic variation in analyzing the overall competitive effects of the proposed Aetna/Humana merger. In many cases, disparate geographies can be characterized by different market structures, either as a result of demographics, private insurer business models, or, in the case of HMOs regulatory and legal restrictions. The purpose is to examine these geographic markets to see if the changes and impacts reported on a statewide basis are uniform, or are more concerning in some areas rather than others. In this more detailed analysis, geographic granularity is combined with segmentation in product markets to gain some insight into where more specific issues and concerns might arise.

There are a number of ways to segment the Florida market geographically. Much of the work done in insurance market structure in Florida for regulatory and policy purposes relies upon reporting done on a by county basis.<sup>9</sup> The data could alternatively be grouped by regions as defined by the AHCA in their reporting.<sup>10</sup> Finally, The AMA uses data grouped by MSAs in their reporting of health insurance and competition<sup>11</sup>. These last two regional groupings are important as they may well obviate the methodological and interpretive issued by providing additional stability and robustness to the county analysis where seemingly small changes in less populated counties can skew overall interpretations.

### ***Analysis by County***

Table 2 below provides the estimated pre- and post-merger HHI measures for each line of business considered for each of Florida's sixty seven counties, using the same data reported for the statewide analysis above. If neither Aetna nor Humana wrote a line of business, it was omitted from the Table.

The data in Table 2 show that much of what was found on a statewide basis is retained when examining the product line market on a more detailed geographic basis. In the group insurance markets, only two counties (Broward and Miami-Dade) had HHI index values that fell below the highly concentrated range for Small Group, all of the counties showed high concentration values for Medium Group, and eight counties showed moderate concentration for Large Group.

The post-merger calculations suggest that both of the moderately concentrated counties move just into the highly concentrated range for Small Group, all of the counties show, of course, continued measures of being highly concentrated for Medium Group, and six of the eight moderately concentrated counties move over the threshold into the highly concentrated range for Large Group. The data in Table 2 also show that the most dramatic impact seems to occur in more populous counties.

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<sup>9</sup> The analysis begins with by county reporting. While the county level analysis does provide interesting insights, there is always a concern that results from significantly smaller counties can skew overall interpretations.

<sup>10</sup> The mapping of counties into AHCA regions is included in the Appendix 3.

<sup>11</sup> See AMA report and Appendix 3 for MSA definitions used in this analysis.

**Table 2: County Level HHI for Enrollment by County**

County	Small Group			Medium Group			Large Group			Individual			Medicare Advantage			Medicaid		
	HHI Before*	HHI After	Increase HHI Attn/Humana	HHI Before	HHI After	Increase HHI Attn/Humana	HHI Before	HHI After	Increase HHI Attn/Humana	HHI Before	HHI After	Increase HHI Attn/Humana	HHI Before	HHI After	Increase HHI Attn/Humana	HHI Before*	HHI After	Increase HHI Attn/Humana
Alachua	6,338	6,314	4	4,694	4,624	-7	4,094	4,069	-3	8,495	8,298	-2	5	5	5	3,524	3,524	0
Baker	3,338	3,290	149	4,841	4,841	0	4,909	4,909	0	8,434	8,440	4	4,760	4,814	54	3,282	3,278	0
Bay	7,832	7,832	0	4,409	4,409	0	4,703	4,705	2	7,113	7,115	2	9,196	9,200	0	2,879	2,956	127
Bradford	4,516	4,516	0	4,540	4,542	2	4,540	4,542	2	7,743	7,746	3	4,096	4,227	131	3,302	3,362	0
Brevard	3,259	3,285	26	3,564	3,566	2	3,289	3,216	7	7,401	7,427	287	3,406	3,463	57	3,192	3,192	0
Broward	2,155	2,093	680	2,913	3,252	368	2,079	2,872	856	4,603	5,097	494	2,937	3,531	2,395	4,212	4,212	0
Citrus	7,067	7,080	2	4,823	4,824	1	4,823	4,824	1	7,949	7,955	6	5,294	5,300	6	2,374	2,384	29
Collier	3,816	3,954	138	5,434	5,438	5	3,602	3,623	20	4,406	5,031	631	2,498	3,144	740	6,821	6,821	0
Columbia	3,135	3,136	0	5,817	5,848	31	5,726	7,026	134	8,147	8,147	0	5,294	5,300	6	4,474	4,474	0
DeSoto	2,361	2,678	317	3,319	3,541	222	2,399	2,693	259	3,085	3,494	409	2,465	2,478	11	1,657	1,661	144
Dixie	4,249	4,272	23	5,632	5,632	0	4,999	4,999	0	7,645	7,648	3	3,711	4,077	364	7,395	7,395	0
Dixie	5,727	5,727	0	6,490	6,490	0	4,315	4,315	0	7,390	7,399	0	4,331	4,475	144	4,091	4,091	0
Dixie	3,460	3,549	83	4,200	4,266	66	3,902	3,902	0	4,086	5,006	248	2,550	3,040	507	2,918	2,918	0
Franklin	3,663	4,370	7	4,747	4,747	0	5,551	6,551	0	5,514	5,824	311	2,686	2,881	176	9,390	9,390	0
Flagler	4,680	4,826	148	4,977	4,991	14	4,794	4,808	14	6,760	6,805	45	3,824	4,099	275	3,468	3,468	0
Franklin	9,383	9,383	0	9,818	9,818	0	8,310	8,316	0	9,026	9,026	0	3,267	3,378	111	8,067	8,067	0
Gadsden	9,219	9,219	0	7,584	7,584	0	9,650	9,850	0	8,629	8,639	10	4,368	4,371	4	8,824	8,824	0
Gadsden	5,447	5,541	95	4,879	4,879	0	8,374	8,374	0	8,374	8,374	0	3,244	3,279	37	7,364	7,364	0
Gaines	6,672	6,672	0	7,759	7,759	0	5,428	5,428	0	7,688	7,688	0	5,078	5,281	124	4,803	4,803	0
Gulf	9,485	9,485	0	9,339	9,330	0	6,761	6,761	0	9,243	9,283	0	3,081	3,231	130	7,664	7,664	0
Hamilton	7,257	9,257	190	7,388	7,388	0	6,505	6,505	0	8,359	8,363	4	4,077	4,244	168	3,608	3,608	0
Hancock	4,876	4,899	23	5,276	5,276	0	4,810	4,819	9	8,419	8,422	2	3,476	3,614	137	4,161	4,162	1
Hendry	7,299	7,299	0	7,823	7,825	2	4,200	4,200	0	8,737	8,737	10	5,050	5,276	126	5,244	5,244	0
Hernando	3,494	3,732	239	4,263	4,263	0	5,267	5,421	54	7,593	7,636	42	2,598	2,675	76	4,628	4,628	0
Hillsborough	2,956	3,326	371	3,445	3,618	172	3,266	3,268	99	4,231	4,806	575	3,166	3,891	326	4,158	4,160	8
Holmes	8,421	8,421	0	8,461	8,461	0	7,033	7,032	0	8,720	8,723	3	3,879	3,911	41	6,491	6,491	0
Irving	6,561	6,561	3	8,700	8,700	2	8,474	8,474	2	8,474	8,474	3	2,010	2,010	127	4,924	4,924	126
Jackson	6,063	9,063	291	7,310	7,310	0	4,046	4,046	0	8,673	8,673	0	3,755	3,856	103	7,430	7,430	0
Jefferson	9,844	9,844	0	8,499	8,496	0	9,500	9,500	0	8,992	8,911	19	4,304	4,311	7	7,965	7,965	0
Lafayette	9,851	9,851	0	9,690	9,690	0	5,590	5,590	0	9,499	9,499	0	3,835	3,807	172	4,326	4,326	0
Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3,343	0
Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3,343	0
Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3,343	0
Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3,343	0
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Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3,343	0
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Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3,343	0
Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3,343	0
Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3,343	0
Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3,343	0
Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3,343	0
Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3,343	0
Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3,343	0
Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3,343	0
Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3,343	0
Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3,343	0
Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3,343	0
Lake	4,055	4,137	83	4,462	4,484	21	3,374	3,406	32	3,835	3,807	172	2,070	2,220	151	3,343	3	

equal, seem to be where the more dramatic changes in market concentration occur across the lines of business.

### ***Analysis by AHCA Region***

The Agency for Health Care Administration (AHCA) is the state agency in Florida responsible for administering and overseeing the state's Medicaid program. For their purposes, Florida's counties are grouped into eleven regions. These regions provide some geographic and demographic stability that is useful for the analytical purposes of this report.

For this part of the analysis, the collected data were divided into AHCA regions and the resulting pre- and post- proposed merger HHI index values were calculated for each region for each line of business under consideration. The results appear in Table 3.

**Table 3: HHI for Enrollment by AHCA Region**

Region	Small Group		Medium Group		Large group		Individual		Medicare Advantage		Medicaid	
	Pre-Merger	Post-Merger	Pre-Merger	Post-Merger	Pre-Merger	Post-Merger	Pre-Merger	Post-Merger	Pre-Merger	Post-Merger	Pre-Merger	Post-Merger
1	4,334	4,342	4,661	4,662	6,394	6,394	7,065	7,185	<b>2,544</b>	2,723	9,487	9,487
2	8,899	8,899	7,401	7,402	8,835	8,835	8,960	8,965	3,827	3,858	8,197	8,197
3	5,000	5,034	5,148	5,153	5,483	5,492	7,884	7,918	<b>2,247</b>	<b>2,361</b>	3,800	3,800
4	3,761	3,856	4,352	4,362	4,560	4,573	5,179	5,445	3,153	3,526	<b>2,414</b>	<b>2,414</b>
5	2,541	3,345	3,253	3,517	<b>2,295</b>	3,249	4,010	4,754	2,679	2,887	<b>2,546</b>	<b>2,546</b>
6	2,890	3,266	3,587	3,711	<b>2,259</b>	2,924	4,150	4,771	2,670	3,036	<b>2,343</b>	<b>2,347</b>
7	2,661	2,835	3,165	3,207	<b>2,341</b>	<b>2,395</b>	3,762	4,528	<b>2,314</b>	<b>2,399</b>	<b>2,306</b>	<b>2,306</b>
8	4,183	4,240	5,721	5,726	4,300	4,334	6,296	6,431	<b>2,206</b>	2,816	6,950	6,950
9	3,881	4,067	4,241	4,320	<b>2,472</b>	2,638	3,565	4,355	3,848	4,109	5,747	5,753
10	<b>2,155</b>	2,935	2,913	3,282	<b>2,015</b>	2,872	4,063	5,997	2,937	5,331	4,212	4,212
11	<b>2,354</b>	2,666	3,301	3,523	<b>2,369</b>	2,656	2,985	3,378	<b>2,465</b>	<b>2,480</b>	<b>1,646</b>	<b>1,788</b>

**Bold** Indicates an HHI between 1500 and 2500  
**Normal** Indicates an HHI over 2500  
**10,000** Monopoly

For the group insurance markets, the results overall tend to show that the level of market concentration in evidence before the merger does not change classification categories when the impact of the proposed merger is considered. That is, if a market was moderately concentrated before the proposed merger, it tended to remain so after the proposed merger, and of course, markets characterized as highly competitive before the proposed merger remain so afterwards. The exceptions are in Regions 10 and 11 for Small Group insurance, and Regions 5, 6, 9, 10, and 11 for Large Group insurance.

The Individual market is measured as highly concentrated in every AHCA region prior to the merger as well as after considering the proposed merger.

The Medicare Advantage market does show some noticeable variation across regions. Markets that were highly concentrated remain so, Regions 3, 7 and 11 remain moderately competitive before and after considering the proposed merger; Region 8 is moderately concentrated prior to consideration of the merger moving to highly concentrated after considering the merger and Region 10 while measured as highly concentrated prior to the proposed merger, shows a substantial increase in measure market concentration following the proposed merger.

In the Medicaid market, regions tend to be bifurcated into either highly concentrated or moderately concentrated prior to considering the merger. The market concentration following the proposed merger remains in the same range for each region, in fact almost the same measure, following the proposed merger, signifying the minimal impact of the proposed merger on this market.

### **Analysis by MSA**

Finally, the collected data are sorted into defined MSAs. This grouping allows the analysis to be roughly consistent with analyses presented from other sources.<sup>12</sup> In order to provide a complete view of all of the markets within the Florida state boundaries, the analysis presented here had to add three regions undefined in the MSA specifications. These are the three areas labeled Northwest, North, and South, and as shown in Appendix 3, include smaller, less populated counties of the state not otherwise considered in an MSA based analysis. Table 4 summarizes the MSA based analysis

**Table 4: HHI for Enrollment by MSA – by Line**

	Small Group		Medium Group		Large group		Individual		Medicare Advantage		Medicaid	
	Pre-Merger	Post-Merger	Pre-Merger	Post-Merger	Pre-Merger	Post-Merger	Pre-Merger	Post-Merger	Pre-Merger	Post-Merger	Pre-Merger	Post-Merger
Pensacola-Ferry Pass-Brent, FL	4,453	4,457	4,594	4,594	6,277	6,277	5,943	6,192	2,560	2,742	9,448	9,448
Crestview-Ft Walton Beach-Destin	4,290	4,305	4,943	4,946	6,356	6,356	9,110	9,116	3,000	3,172	9,540	9,540
Panama City-Lyn Haven-Panama City Beach	7,832	7,832	4,909	4,909	7,115	7,115	9,199	9,200	2,829	2,956	8,493	8,493
Tallahassee	9,229	9,229	7,963	7,964	9,457	9,457	8,977	8,986	5,803	5,812	8,388	8,388
Jacksonville	3,514	3,583	4,322	4,324	4,048	4,065	5,377	5,625	2,696	3,196	2,609	2,609
Gainesville	6,267	6,271	5,774	5,774	4,774	4,777	9,163	9,169	3,138	3,284	3,533	3,533
Palm Coast	4,680	4,826	4,977	4,991	4,794	4,808	6,760	6,805	3,824	4,099	3,468	3,468
Ocala	5,939	5,948	6,382	6,382	7,110	7,113	8,492	8,516	2,537	2,581	4,088	4,088
Deltona-Daytona Beach-Ormond Beach	5,083	5,156	4,459	4,476	5,830	5,835	4,615	4,943	4,038	4,208	3,680	3,680
Orlando-Kissimme-Sanford	3,326	3,517	4,041	4,095	2,551	2,616	4,109	4,509	2,683	2,795	<b>2,245</b>	<b>2,245</b>
Palm Bay-Melbourne-Titusville	3,259	3,285	3,564	3,566	<b>2,209</b>	<b>2,216</b>	4,727	5,014	3,406	3,463	3,214	3,214
Sebastian-Vero Beach	6,359	6,361	5,769	5,769	3,400	3,402	8,478	8,481	<b>1,984</b>	<b>2,105</b>	4,498	4,624
Tampa-St. Petersburg-clearwater	2,718	3,266	3,356	3,566	<b>2,320</b>	3,178	4,188	4,804	2,747	2,950	<b>2,307</b>	<b>2,308</b>
Lakeland-Winter Haven	3,193	3,396	3,883	3,979	2,605	2,814	5,083	5,344	<b>2,370</b>	2,570	<b>2,452</b>	<b>2,455</b>
Punta Gorda	3,816	3,954	5,434	5,438	3,602	3,623	4,400	5,031	<b>2,404</b>	3,144	6,821	6,821
Port St. Lucie	4,734	4,759	4,701	4,701	3,804	3,830	7,587	7,615	2,957	3,153	4,777	4,824
Cape Coral-Ft. Myers	4,015	4,059	5,784	5,789	4,240	4,286	6,180	6,234	<b>2,484</b>	2,852	7,682	7,682
Naples-Marco Island	7,078	7,087	6,424	6,424	4,179	4,203	7,800	7,855	2,980	3,520	4,975	4,975
Miami-Ft Lauderdale-Pompano Beach	<b>2,262</b>	2,702	3,081	3,330	<b>2,060</b>	2,535	2,645	3,964	2,574	3,549	3,254	3,329
North Port-Bradenton-Sarasota	3,717	3,865	4,420	4,427	4,132	4,210	5,986	6,144	<b>1,943</b>	2,738	4,633	4,636
<b>Northwest</b>	6,653	6,660	6,802	6,802	6,359	6,360	8,821	8,827	3,323	3,437	4,703	4,703
<b>North</b>	5,647	5,659	5,651	5,651	6,110	6,111	8,315	8,327	2,671	2,837	4,205	4,205
<b>South</b>	4,969	4,999	4,755	4,764	3,872	3,885	5,524	5,545	3,589	2,837	3,779	3,794

**Bold** Indicates an HHI value between 1500 and 2500  
**Normal** Indicates an HHI value over 2500

For the Small Group market, nineteen out of the twenty defined MSAs are characterized as highly concentrated prior to the merger. Following the proposed merger, based on the data, the calculations show all twenty defined MSAs as highly concentrated. For the three newly defined “small county” regions, all are highly concentrated and no significant additional concentration is shown following the merger.

<sup>12</sup> See AMA report, testimony and data from Aetna/Humana application and public hearing. <http://www.floir.com/siteDocuments/AetnaHumanaPublicComments.pdf>

For the Medium Group market, all twenty defined MSAs are measured as highly concentrated before the proposed merger, and remain so afterward with no substantial increases in concentration beyond what was already evident.

For the Large Group market, seventeen of the twenty defined MSAs were measured as highly concentrated prior to the merger. Following the proposed merger, the analysis indicates nineteen MSAs are highly concentrated, with substantial increases in concentration in the Tampa-St. Petersburg-Clearwater and Miami-Ft. Lauderdale-Pompano Beach MSAs. The Palm Bay-Melbourne-Titusville MSA was moderately concentrated prior to the merger, and remains so following the proposed merger.

Again, the three small county MSAs were highly concentrated prior to the merger, and remain largely unchanged after the proposed merger.

In the Individual market, every MSA had a measured HHI that would be considered highly concentrated, though the range varied from 2,645 in the Miami-Ft. Lauderdale-Pompano Beach MSA to 9,199 in the Panama City-Lynn Haven-Panama City Beach MSA. When calculated on a post-merger basis, the most significant increases in market concentration were found in the Palm Bay-Melbourne-Titusville, Lakeland-Winter Haven, and Miami-Ft. Lauderdale-Pompano Beach MSAs. The remaining MSAs, including the small county MSAs showed only marginal increases in concentration.

In the Medicare Advantage market, the pre-merger calculated HHIs for five MSAs (Sebastian-Vero Beach, Lakeland-Winter Haven, Punta Gorda, Cape Coral-Ft. Myers and Sarasota) were in the moderately concentrated range, the remainder of the defined MSAs and the small county MSAs had calculated HHIs in the highly concentrated range. When the post-merger HHIs were calculated, only the Sebastian-Vero Beach MSA continued to be considered moderately concentrated. The remaining four that were previously moderately concentrated, migrated into the highly concentrated range, in most cases substantially so.

In the Medicaid market, 3 MSAs (Orlando-Kissimmee-Sanford, Tampa-St. Petersburg-Clearwater, and Lakeland-Winter Haven) were considered moderately concentrated in the pre-merger calculations, the remainder, including the small county MSAs were highly concentrated. The post-merger calculations showed no meaningful change in concentration in any MSA.

### ***Medicare Advantage and Traditional Medicare***

The Medicare Advantage line and market considered to this point differs fundamentally from the other insurance lines considered in this proposed merger. Medicare Advantage, the private market product, competes directly with traditional Medicare which is the product offered by the Federal government. Thus, when considering the impact of the merger, viewing only the private market condition is to view only a portion of the market. For example, Table 5 shows the relative importance of traditional Medicare in the Florida market.

Based on 2014 data on enrollees, traditional Medicare is 62.5% of the market. That is, the entire private Medicare Advantage market is less than half of the total market.

As Table 5 shows, when viewed as the combination of the public and private products, the Medicare market on a statewide basis is viewed as highly concentrated. Moreover, the impact of the proposed merger does not change the measured HHI by any noticeable amount. On a pre-merger basis, when the total market, public and private, is considered, Humana had a 14.8% market share and Aetna had a 2.2% market share, so that on a post-merger basis, the combined entity would have a 17.1% market share.

**Table 5: Medicare Advantage vs. Traditional Medicare**

	Enrollment	Market Share	Pre-Merger HHI	Post-Merger Share	Post-Merger HHI
Medicare Advantage	1,418,013	37.4%			
Traditional Medicare	2,367,608	62.5%	3911	62.50%	3911
Aetna		2.20%	5	17.10%	291
Humana		14.80%	220		

The statewide results from Table 5 stand in sharp contrast to the statewide results for Medicare Advantage only, as first shown in Table 1 but repeated below in Table 6.

**Table 6: Aetna/Humana vs. Medicare Advantage**

	Pre-Merger HHI	Post-Merger Share	Post-Merger HHI
Aetna/Humana Medicare Advantage	2,229	45.60%	2,713

If only the private Medicare Advantage market is considered, the moderately competitive market observed prior to the proposed merger, moves slightly into the highly concentrated range and the combined Aetna/Humana entity has a market share of 45.6%.

That is, currently traditional Medicare is the dominant market power on a statewide basis for Medicare. The proposed merger creates a larger entity, particularly large if only the private market is considered. But on a broader basis, the proposed merger creates an entity with still less than a third of the traditional Medicare footprint.

While traditional Medicare data were only available on a statewide basis, the Medicare Advantage market can be viewed along the MSA geographic breakdown, as first reported in Table 4. Table 7 repeats the results from Table 4 and adds four firm concentration ratios.

Table 7 shows that considered on a pre-merger basis, the Medicare Advantage market was moderately concentrated in 5 MSAs with the remainder being highly concentrated. The post-merger calculations show that only one market remained moderately competitive. Table 7 also shows the MSA percentage of the overall Medicare Advantage market and the four firm concentration ratios for each MSA before and after consideration of the proposed merger.

**Table 7: MSA Summary-Medicare Advantage**

MSA Name	MSA #	MSA Share of State		HHI				Four-Firm Concentration			
		Enrollment	Share of Total	Pre-Merger HHI	Post-Merger HHI	Increase in HHI Aetna/Humana	Increase in HHI Anthem/Cigna	Pre-Merger	Post-Merger	Gross Δ Four-firm	% Δ Four-firm
Pensacola-Ferry Pass-Brent, FL	1	21,571	1.52%	2,560	2,742	182	0	86%	89%	2.19%	2.53%
Crestview-Ft Walton Beach-Destin	2	3,860	0.27%	3,000	3,172	171	0	98%	100%	2.28%	2.33%
Panama City-Lyn Haven-Panama City Beach	3	5,233	0.37%	2,829	2,956	127	0	96%	98%	1.74%	1.81%
Tallahassee	4	22,651	1.60%	5,803	5,812	9	0	100%	100%	0.49%	0.49%
Jacksonville	5	54,833	3.87%	2,696	3,196	500	0	93%	100%	6.30%	<b>6.74%</b>
Gainesville	6	5,993	0.42%	3,138	3,284	146	0	98%	100%	2.10%	2.15%
Palm Coast	7	10,522	0.74%	3,824	4,099	275	0	98%	100%	1.98%	2.02%
Ocala	8	32,596	2.30%	2,537	2,581	45	0	89%	90%	1.72%	1.94%
Deltona-Daytona Beach-Ormond Beach	9	53,247	3.75%	4,038	4,208	170	0	96%	97%	1.48%	1.55%
Orlando-Kissimee-Sanford	10	138,269	9.75%	2,683	2,795	112	0	92%	92%	0.00%	0.00%
Palm Bay-Melbourne-Titusville	11	45,162	3.18%	3,406	3,463	57	0	91%	93%	1.89%	2.07%
Sebastian-Vero Beach	12	8,262	0.58%	<b>1,984</b>	<b>2,105</b>	121	0	83%	87%	3.25%	3.90%
Tampa-St. Petersburg-Clearwater	13	258,467	18.22%	2,747	2,950	204	0	86%	88%	2.24%	2.60%
Lakeland-Winter Haven	14	52,862	3.73%	<b>2,370</b>	2,570	200	0	84%	87%	2.60%	3.10%
Punta Gorda	15	15,759	1.11%	<b>2,404</b>	3,144	740	0	89%	100%	10.74%	<b>12.07%</b>
Port St. Lucie	16	27,892	1.97%	2,957	3,153	196	0	91%	93%	2.15%	2.36%
Cape Coral-Ft. Myers	17	43,333	3.05%	<b>2,484</b>	2,852	368	0	92%	99%	7.78%	<b>8.49%</b>
Naples-Marco Island	18	14,054	0.99%	2,980	3,520	540	0	95%	100%	5.39%	5.70%
Miami-Ft Lauderdale-Pompano Beach	19	486,963	34.33%	2,574	3,549	896	80	82%	92%	9.48%	<b>11.55%</b>
North Port-Bradenton-Sarasota	20	52,596	3.71%	<b>1,943</b>	2,738	795	0	85%	95%	10.18%	<b>11.93%</b>
<b>Northwest</b>	97	6,660	0.47%	3,323	3,437	115	0	99%	100%	1.43%	1.45%
<b>North</b>	98	43,381	3.06%	2,671	2,837	166	0	95%	98%	2.69%	2.82%
<b>South</b>	99	14,337	1.01%	3,589	3,915	326	0	97%	100%	3.32%	3.43%

Those data suggest that, roughly, the larger MSAs had lower four firm concentration ratios (e.g. more market participants) than did smaller MSAs. In the far right column, the percentage change in the four firm concentration ratios is shown. Five MSAs showed a percentage increase of over 5% following the proposed merger, an indication that these are the areas where the competitive impact of the merger is most likely to be seen on this 37% of the total Medicare market.

The data in Table 7 also show that for the small county MSAs calculated for this report, the four firm concentration ratios pre-merger ranged from 97 to 99% and were essentially 100% on a post-merger calculation. Given that CMS has previously reported that the private market penetration rate in these less populated areas was dramatically lower than in more populous regions, these results suggest that there is little direct competitive gain from the merger for these areas, which comprise roughly 4.5% of the total private Medicare Advantage enrollees.<sup>13</sup>

Care must be used in interpreting the results that combine traditional Medicare and Medicare Advantage from a market power, competitive structure viewpoint. The underpinning behind the analysis used throughout this report is that market structures are stable. It is not clear that assumption holds strongly in this instance. Terms and conditions for traditional Medicare can change at almost any time depending on changes made by Federal legislation or by changes in the interpretation of rules and requirements.

There is a sense that a number of changes are either impending or being considered moving forward, which could have a dramatic impact on traditional Medicare and the interaction between traditional Medicare and Medicare Advantage in the marketplace.

<sup>13</sup> See CMS data from 2005 for Florida, the latest year this data were publicly available from CMS web site.

In reaching its conclusion that Medicare Advantage competes directly with traditional Medicare, the Office analyzed a number of factors and market conditions, including but not limited to the following:

- **Market Fluidity.** Data analysis from 2013-2015 indicates that, annually, 21-25% of Aetna or Humana enrollees transition from Medicare Advantage to traditional Medicare. In addition, according to a study conducted by Harvard School of Public Health and Harvard Medical School, which examined the patterns for demand and enrollment into Medicare Advantage in Miami-Dade County, 5-7% of traditional Medicare enrollees transitioned to Medicare Advantage annually.<sup>14</sup> This transition experience demonstrates that fluidity and, therefore, direct competition exists between Medicare Advantage and traditional Medicare.
- **Market Dynamic.** Most Medicare Advantage plans offer substantially richer benefits at lower costs to enrollees than traditional Medicare in exchange for receiving care in a managed, network setting. The market dynamic that exists between Medicare Advantage and traditional Medicare is similar in nature to the dynamic between a commercial market HMO and PPO, which clearly operate and function as direct competitors.
- **Value Proposition.** The U.S. Department of Justice<sup>15</sup> and another Harvard School of Public Health and Harvard Medical School study<sup>16</sup> have concluded that Medicare Advantage plans offer equal or higher benefits and quality of care for less cost than traditional Medicare, bolstering the argument that consumers benefit from comparing traditional Medicare to Medicare Advantage. Historical Medicare enrollment data provides insights into how the value of Medicare Advantage relative to traditional Medicare drives consumer behavior. For example, in 1999, the Medicare Advantage Florida market penetration was 27%<sup>17</sup>; however, as a result of reduced plan payments within the Medicare program,<sup>18</sup> the Medicare Advantage Florida market penetration declined to a low of 18% in 2004.<sup>19</sup> Around that time the Medicare program was changed again,<sup>20</sup> which resulted in an increase

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<sup>14</sup> Sinaiko, Afendulis, & Frank, Enrollment in Medicare Advantage Plans in Miami-Dade County: Evidence of Status Quo Bias?, 50 Inquiry 202 (2013), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4108259>.

<sup>15</sup> Complaint at 5-6, United States v. Humana, Inc., Case No. 1:12-cv-00464 (D.D.C. Mar. 27, 2012), available at <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/12-0010-DOJ-Filing.pdf>.

<sup>16</sup> Newhouse & McGuire, How Successful Is Medicare Advantage?, 92 The Milbank Quarterly 351 (2014), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4089375>.

<sup>17</sup> The Henry J. Kaiser Family Foundation, Medicare Advantage Enrollees as a Percent of Total Medicare Population, <http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population>.

<sup>18</sup> Balanced Budget Act of 1997, Pub. L. No. 105-32, available at <https://www.gpo.gov/fdsys/pkg/BILLS-105hr2015enr/pdf/BILLS-105hr2015enr.pdf>.

<sup>19</sup> The Henry J. Kaiser Family Foundation, Medicare Advantage Enrollees as a Percent of Total Medicare Population, <http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population>.

<sup>20</sup> Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, available at <https://www.gpo.gov/fdsys/pkg/PLAW-108publ173/pdf/PLAW-108publ173.pdf>.

in the Medicare Advantage Florida market penetration, reaching a maximum of 40% in 2015.<sup>21</sup> These market shifts indicate that consumers recognize and understand the value differential between Medicare Advantage and traditional Medicare and the changes therein. If Aetna or its affiliates, rather than the CMS, were to increase premiums or reduce benefits, thereby reducing the value to consumers, it is likely that a greater number of consumers would choose traditional Medicare, demonstrating again that Medicare Advantage and traditional Medicare are direct competitors.

- **The Future of Medicare.** Regulatory changes to Medicare and Medicare Supplement are increasing the similarities between Medicare Advantage and traditional Medicare, which is likely to create additional competition in the near future. For example, in 2015, the Secretary of Health and Human Services was directed by Congress to develop a Merit-based Incentive Payment system.<sup>22</sup> In addition, the CMS Innovation Center is actively working on a plan to use Medicare Supplement for managing the care provided by traditional Medicare. These changes narrow the differences that exist between Medicare Advantage and traditional Medicare, which will increase the likelihood that a Medicare Advantage enrollee will transition to traditional Medicare and increase the competition between the Medicare Advantage and traditional Medicare.
- **The Consumer Experience.** When shopping for coverage on Medicare.gov, consumers are provided with a direct comparison of Medicare Advantage plans and traditional Medicare. The juxtaposition of these two plans on the CMS website demonstrates that traditional Medicare provides a competitive restraint on Medicare Advantage by requiring that Medicare Advantage plans provide more value than traditional Medicare.

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<sup>21</sup> The Henry J. Kaiser Family Foundation, Medicare Advantage Enrollees as a Percent of Total Medicare Population, <http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population>.

<sup>22</sup> Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, available at <https://www.congress.gov/bill/114th-congress/house-bill/2>.

## **Summary of Findings**

This report has analyzed the competitive impact of the proposed Aetna and Humana merger on Florida health insurance markets. On the whole this report finds that the majority of geographic and product markets identified are characterized as either moderately or highly concentrated before consideration of the proposed merger based on the most recent data available. The impact of the merger in the markets then is a matter of the degree to which the already existing conditions for the ability of market power to be exercised is enhanced and not where the merger would create the opportunity for the exercise of market power where it did not previously exist.

For several decades Florida laws, and more recently federal laws, have included MLR requirements. For the markets considered in this report the MLRs range from 80% to 85%. These requirements guarantee that consumers will receive eighty to eighty-five cents in healthcare services for every dollar of premium paid and they effectively limit any entities ability to exercise market power, independent of concentration. In addition, monopsony power is limited by state and federal laws requiring health maintenance organizations and exclusive provider organizations to have a minimum number healthcare providers and facilities available in a specific market. The network adequacy requirements placed on insurers are currently under significant scrutiny and will likely be expanded in the near future.

Whether using county definitions, AHCA region definitions or MSA region definitions, the results are similar and show some increase in the degree of concentration that would be viewed as meaningful in some Group insurance markets, relatively few Individual markets, and most noticeably in the Medicare Advantage markets. The impact generally is more noticeable in the more populous regions. Smaller population areas do not seem to experience any meaningful impact from the proposed merger.

The relatively strong impact in the Medicare Advantage markets should be viewed in context. While the degree of concentration rises sharply in some regions in the private Medicare Advantage markets, it is also true that when traditional Medicare is considered, the proposed merger does little to impact the dominance of the Federal program throughout the state. This market warrants additional monitoring moving forward as it is difficult to characterize it as a stable market.

Taken as a whole, while there may be some particular product and regional areas where additional factors and discussion, outside the scope of this analysis, is likely appropriate, in general there is not strong evidence of an overall significant reduction in the competitive landscape of the private Florida health insurance markets resulting from this proposed merger.

## **Appendix 1: OIR Data Call**

The data underlying this report were obtained through the Major Medical and Medicare Advantage (MMMA) data call performed by the Office of Insurance Regulation in the Fall of 2015. Data were requested at the county level from a constrained list of companies that make up roughly 95% of Florida GAP reported premiums as collected in the *Accident & Health Markets Gross Annual Premium and Enrollment Summary CY 2014* (GAP). While constrained by design, the scope and breadth of business represented in the data call is sufficient to draw meaningful insights as to the competitive effects on the Florida market resulting from the proposed merger between of Humana by Aetna.

A copy of the data call template appears on the next page.



## **Appendix 2: Product Line Definitions**

**Major Medical:**

A hospital/surgical/medical expense contract that provides comprehensive benefits as defined in the state in which the contract will be delivered. In Florida this means insurance that is designed to cover expenses of serious illness, chronic care (excluding long-term care) and/or hospitalization. The term does NOT include accident-only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, prepaid products, Medicare supplement, long-term care, or disability income insurance; similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which do not duplicate coverage under an underlying health plan and are specifically designed to fill gaps in the underlying health plan, coinsurance, or deductibles; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance. The following subcategories are included:

- i. Small Group: 02-50 members (FS 627.6699)
- ii. Medium Group: 51-100 members (FS 627.6699)
- iii. Large Group: 101+ members (FS 627.652)
- iv. Individual: policies which are individually issued.
- v. Commercial group Conversion: Guarantees an insured whose coverage is ending for specified reasons a right to purchase a policy without presenting evidence of insurability.
- vi. Other Commercial: NOT to include the following: Medicare (all Titles), Medicare + Choice, HCPP, Medicaid (all Titles), SCHIP, FEHBP, Florida Healthy Kids, Florida Health Flex Plans, self-insured business, credit (group and individual), or credit A&H (group and individual).

**Medicare Advantage:**

Also known as Medicare Part C, includes the private health plans through which beneficiaries have chosen to receive all of their Medicare benefits. These include:

- i. Coordinated care plans such as Health Maintenance Organizations (HMOs), provider-sponsored organizations (PSOs), regional or local preferred provider organizations (PPOs), and other network plans (other than private fee-for-service plans) [42 C.F.R. §422.4(a)(1)(iii).]
- ii. Private Fee for Service Plans [42 C.F.R. §422.4(a)(3).] and
- iii. Medical savings accounts which are comprised of an MA medical savings account plan that pays for a basic set of health benefits approved by CMS and an MSA trust or custodial account into which CMS will make deposits. [42 C.F.R. §422.4(a)(2).]

*\*The above definitions were directly from the CY 2014 GAP Report.*

**Healthy Kids:**

Florida Healthy Kids offers health insurance for children ages 5 through 18. **The Florida Healthy Kids program is a part of Florida KidCare, the state's high-quality, low-cost health insurance for children. Florida KidCare was created through Title XXI of the Social Security Act.**<sup>i</sup>

**Medicaid:**

Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations that accept a set per member per month (capitation) payment for these services.<sup>ii</sup>

**Federal Employees:**

The FEHB Program allows employees to choose from among Consumer-Driven and High Deductible plans that offer catastrophic risk protection with higher deductibles, health savings/reimbursable accounts and lower premiums, or Fee-for-Service (FFS) plans, and their Preferred Provider Organizations (PPO), or Health Maintenance Organizations (HMO) if you live (or sometimes if you work) within the area serviced by the plan.<sup>iii</sup>

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i *What is Florida Health Kids?* Florida Healthy Kids, a Florida Kidcare Partner, 2016.

<https://www.healthykids.org/healthykids/what/>

Compilation of Social Security Laws

[https://www.ssa.gov/OP\\_Home/ssact/title21/2100.htm](https://www.ssa.gov/OP_Home/ssact/title21/2100.htm)

ii *Medicaid Program Information-Managed Care*, Center for Medicare & Medicaid Services, Medicaid.gov, 2016.

<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>

See Part IV of Chapter 409, Florida Statutes

iii *Federal Employees health Benefits Program (FEHB)*, Operated by the U.S. Office of Personnel Management (OPM), 2016. <https://www.opm.gov/healthcare-insurance/healthcare/>

### **Appendix 3: Geographic Area Definitions**

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## Geographic Regions, County, MSA, AHCA Region

MSA Name	County	AHCA Region
Pensacola-Ferry Pass-Brent, FL	Escambia	1
	Santa Rosa	1
Crestview-Ft Walton Beach-Destin	Okaloosa	1
Panama City-Lyn Haven-Panama City Beach	Bay	2
Tallahassee	Gadsden	2
	Leon	2
	Jefferson	2
	Wakulla	2
Jacksonville	Baker	4
	Nassau	4
	Duval	4
	Clay	4
	St. Johns	4
Gainesville	Gilchrist	3
	Alachua	3
Palm Coast	Flagler	4
Ocala	Marion	3
Deltona-Daytona Beach-Ormond Beach	Volusia	4
Orlando-Kissimmee-Sanford	Lake	3
	Seminole	7
	Orange	7
	Osceola	7
Palm Bay-Melbourne-Titusville	Brevard	7
Sebastian-Vero Beach	Indian River	9
Tampa-St. Petersburg-Clearwater	Hernando	3
	Pasco	5
	Hillsborough	6
	Pinellas	5
Lakeland-Winter Haven	Polk	6
North Port-Bradenton-Sarasota	Manatee	6
	Sarasota	8
Punta Gorda	Charlotte	8

Port St. Lucie	St. Lucie	9
	Martin	9
Cape Coral-Ft. Myers	Lee	8
Naples-Marco Island	Collier	8
Miami-Ft Lauderdale-Pompano Beach	Palm Beach	9
	Broward	10
	Miami-Dade	11

### Unassigned Regions

Northwest	Walton	1
	Holmes	2
	Washington	2
	Jackson	2
	Calhoun	2
	Liberty	2
	Gulf	2
	Franklin	2
North	Madison	2
	Hamilton	3
	Taylor	2
	Lafayette	3
	Suwannee	3
	Columbia	3
	Union	3
	Bradford	3
	Dixie	3
	Levy	3
	Citrus	3
	Sumter	3
	Putnam	3
South	Hardee	6
	DeSoto	8
	Highlands	6
	Okeechobee	9
	Glades	8
	Hendry	8
	Monroe	11



## **FLORIDA OFFICE OF INSURANCE REGULATION**

**Kevin M. McCarty, Insurance Commissioner**

**200 E. Gaines Street – Tallahassee, Florida 32399**

**Phone: (850) 413-3140**

**www.floir.com**



**FILED**

FEB 15 2016

OFFICE OF  
INSURANCE REGULATION  
Docketed by: ODA

## OFFICE OF INSURANCE REGULATION

**KEVIN M. McCARTY**  
COMMISSIONER

### IN THE MATTER OF:

CASE NO. 185926-16-CO

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.

/

### CONSENT ORDER

THIS CAUSE came on for consideration upon the filing by AETNA INC. (hereinafter referred to as "APPLICANT") with the OFFICE OF INSURANCE REGULATION (hereinafter referred to as the "OFFICE") of an application for the indirect acquisition of HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC., HUMANA MEDICAL PLAN, INC., CAREPLUS HEALTH PLANS, INC., and COMPBENEFITS COMPANY (hereinafter referred to as "FLORIDA DOMESTICS") by AETNA INC. pursuant to Sections 628.461, 628.4615, 636.065, and 641.255(3), Florida Statutes (hereinafter referred to as "Application"). Following a complete review of the entire record, and upon consideration thereof, and being otherwise fully advised in the premises, the OFFICE finds as follows:

#### I. PARTIES AND JURISDICTION

1. The OFFICE has jurisdiction over the subject matter and the parties to this proceeding.

2. APPLICANT has applied for and, subject to the terms and conditions established herein, has satisfactorily met all of the conditions precedent to the granting of approval by the

OFFICE of the proposed indirect acquisition of FLORIDA DOMESTICS, pursuant to the requirements of the Florida Insurance Code.

3. APPLICANT affirms that all explanations, representations, and documents provided to the OFFICE in connection with this Application, including all attachments and supplements thereto, are true and correct and fully describe all transactions, agreements, ownership structure, operations, and control of APPLICANT and FLORIDA DOMESTICS.

4. HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC. is a licensed Life & Health Insurer domiciled in the state of Florida and is subject to the jurisdiction and regulation of the OFFICE, pursuant to Chapter 624, Part III, Florida Statutes.

5. HUMANA MEDICAL PLAN, INC. is a licensed Health Maintenance Organization domiciled in the state of Florida and is subject to the jurisdiction and regulation of the OFFICE, pursuant to Chapter 641, Part I, Florida Statutes.

6. CAREPLUS HEALTH PLANS, INC. is a licensed Health Maintenance Organization domiciled in the state of Florida and is subject to the jurisdiction and regulation of the OFFICE, pursuant to Chapter 641, Part I, Florida Statutes.

7. COMPBENEFITS COMPANY is a licensed Prepaid Limited Health Service Organization domiciled in the state of Florida and is subject to the jurisdiction and regulation of the OFFICE, pursuant to Chapter 636, Part I, Florida Statutes.

8. APPLICANT is a Pennsylvania corporation, which is publicly traded on the New York Stock Exchange under the symbol "AET". The Application represents that no individual or entity owns ten percent (10%) or more of APPLICANT's outstanding voting securities.

9. FLORIDA DOMESTICS are ultimately owned one hundred percent (100%) by HUMANA INC. (hereinafter referred to as "HUMANA"), a Delaware holding company. The

Application represents that HUMANA is publicly traded on the New York Stock Exchange under the symbol “HUM” and that no individual or entity owns ten percent (10%) or more of HUMANA’s outstanding voting securities.

## II. ACQUISITION APPLICATION AND PUBLIC HEARING

10. APPLICANT has provided with its Application a copy of an Agreement and Plan of Merger dated July 2, 2015 (hereinafter referred to as the “Merger Agreement”). Pursuant to the terms of the Merger Agreement, in order to effectuate the acquisition of the FLORIDA DOMESTICS, Echo Merger Sub, Inc., a direct, wholly owned subsidiary of APPLICANT created exclusively for this transaction, will merge with and into HUMANA (the first merger), with HUMANA surviving the first merger and becoming a direct wholly owned subsidiary of APPLICANT. Immediately following the first merger, HUMANA will merge with and into Echo Merger Sub, LLC (the second merger), a direct, wholly owned subsidiary of APPLICANT created exclusively for this transaction, with Echo Merger Sub, LLC surviving the second merger. Following the second merger, Echo Merger Sub, LLC will be renamed Humana LLC, and thus, become the ultimate parent company of the FLORIDA DOMESTICS.

11. APPLICANT has also included in its Application copies of the various filings made with the U.S. Securities and Exchange Commission relating to the proposed acquisition, including documentation evidencing that on October 19, 2015, the HUMANA shareholders approved the Merger Agreement.

12. APPLICANT submitted the following opinions in support of the Application:

(a) “Florida Competition Analysis” dated October 6, 2015, in which it was concluded the acquisition is in the public interest and poses no genuine risk of anti-competitive effects in any line of business;

(b) Fairness Opinion issued by Goldman, Sachs, & Co. dated July 2, 2015, which concluded that the consideration to be paid to the holders (other than the APPLICANT and its affiliates) of shares pursuant to the Merger Agreement is fair, from a financial point of view, to such holders;

(c) Fairness Opinion issued by Citigroup Global Markets Inc. dated July 2, 2015, which concluded that the consideration to be paid by the APPLICANT is fair, from a financial point of view, to the APPLICANT; and

(d) Fairness Opinion issued by Lazard, Freres & Co. LLC dated July 2, 2015, which concluded that the consideration to be paid by the APPLICANT is fair, from a financial point of view, to the APPLICANT.

13. On December 7, 2015, the OFFICE convened a public hearing in Tallahassee, Florida for the purpose of obtaining public comment and additional information from the parties involved in the proposed transaction. Notice of the hearing was published in the Florida Administrative Register on November 20, 2015. Upon conclusion of the hearing, the record of the hearing was held open for ten (10) days to allow for additional comment. The transcript of the hearing, all documents and exhibits delivered during the hearing, and all public comments up to the closing of the record were posted on the OFFICE's website located at <http://www.floir.com/Sections/LandH/AetnaHumanaHearing.aspx>.

### III. THE OFFICE'S REVIEW AND ANALYSIS OF THE PROPOSED TRANSACTION

14. Sections 628.461(7)(i)-(j) and 628.4615(8)(i)-(j), Florida Statutes, require that the OFFICE approve the acquisition if it is not likely to be hazardous or prejudicial to the insurer's policyholders or the public and the effect of the acquisition would not substantially lessen competition in insurance in this state or tend to create a monopoly therein.

15. The OFFICE has considered, and relied upon, the materials submitted by APPLICANT in its Application, including the documents referenced in paragraph twelve (12) above.

16. The OFFICE has also considered the documents, exhibits, and public comments submitted as a part of the public hearing record as part of its review of the proposed transaction.

17. In addition to reviewing the materials described above, the OFFICE conducted its own analysis regarding the impact the proposed acquisition may have on market structure and competition specific to Florida.

18. The economic and competitive analysis conducted by the OFFICE determined that the majority of geographic and product markets affected by the proposed acquisition would be characterized as either moderately or highly concentrated before consideration of the proposed acquisition.

19. The analysis conducted by the OFFICE specifically reviewed the impact of the proposed acquisition in the Medicare Advantage markets and found the Medicare Advantage market to be fundamentally different from the other insurance lines considered in the proposed acquisition. Based on its analysis, the OFFICE finds that Medicare Advantage, the private market product, competes directly with Traditional Medicare. Accordingly, when considering the impact of the acquisition, the private market is only a portion of the Medicare market. When analyzed as the combination of the public and private markets, the Medicare market on a statewide basis is highly concentrated, and the impact of the proposed acquisition affects the concentration by only a minimal amount.

20. In reaching its conclusion that Medicare Advantage competes directly with Traditional Medicare, the OFFICE analyzed a number of factors and market conditions, including but not limited to the following:

(a) Market Fluidity. Data analysis from 2013-2015 indicates that, annually, 21-25% of Aetna or Humana enrollees transition from Medicare Advantage to Traditional Medicare. In addition, according to a study conducted by Harvard School of Public Health and Harvard Medical School, which examined the patterns for demand and enrollment into Medicare Advantage in Miami-Dade County, 5-7% of Traditional Medicare enrollees transitioned to Medicare Advantage annually.<sup>1</sup> This transition experience demonstrates that fluidity and, therefore, direct competition exists between Medicare Advantage and Traditional Medicare.

(b) Market Dynamic. Most Medicare Advantage plans offer substantially richer benefits at lower costs to enrollees than Traditional Medicare in exchange for receiving care in a managed, network setting. The market dynamic that exists between Medicare Advantage and Traditional Medicare is similar in nature to the dynamic between a commercial market HMO and PPO, which clearly operate and function as direct competitors.

(c) Value Proposition. The U.S. Department of Justice<sup>2</sup> and another Harvard School of Public Health and Harvard Medical School study<sup>3</sup> have concluded that Medicare Advantage plans offer equal or higher benefits and quality of care for less cost than Traditional Medicare, bolstering the argument that consumers benefit from comparing Traditional Medicare

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<sup>1</sup> Sinaiko, Afendulis, & Frank, Enrollment in Medicare Advantage Plans in Miami-Dade County: Evidence of Status Quo Bias?, 50 Inquiry 202 (2013), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4108259>.

<sup>2</sup> Complaint at 5-6, United States v. Humana, Inc., Case No. 1:12-cv-00464 (D.D.C. Mar. 27, 2012), available at <http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/12-0010-DOJ-Filing.pdf>.

<sup>3</sup> Newhouse & McGuire, How Successful Is Medicare Advantage?, 92 The Milbank Quarterly 351 (2014), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4089375>.

to Medicare Advantage. Historical Medicare enrollment data provides insights into how the value of Medicare Advantage relative to Traditional Medicare drives consumer behavior. For example, in 1999, the Medicare Advantage Florida market penetration was 27%<sup>4</sup>; however, as a result of reduced plan payments within the Medicare program,<sup>5</sup> the Medicare Advantage Florida market penetration declined to a low of 18% in 2004.<sup>6</sup> Around that time the Medicare program was changed again,<sup>7</sup> which resulted in an increase in the Medicare Advantage Florida market penetration, reaching a maximum of 40% in 2015.<sup>8</sup> These market shifts indicate that consumers recognize and understand the value differential between Medicare Advantage and Traditional Medicare and the changes therein. If APPLICANT or its affiliates, rather than the Centers for Medicare and Medicaid Services (“CMS”), were to increase premiums or reduce benefits, thereby reducing the value to consumers, it is likely that a greater number of consumers would choose Traditional Medicare, demonstrating again that Medicare Advantage and Traditional Medicare are direct competitors.

(d) The Future of Medicare. Regulatory changes to Medicare and Medicare Supplement are increasing the similarities between Medicare Advantage and Traditional Medicare, which is likely to create additional competition in the near future. For example, in 2015, the Secretary of Health and Human Services was directed by Congress to develop a Merit-

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<sup>4</sup> The Henry J. Kaiser Family Foundation, Medicare Advantage Enrollees as a Percent of Total Medicare Population, <http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population>.

<sup>5</sup> Balanced Budget Act of 1997, Pub. L. No. 105-32, available at <https://www.gpo.gov/fdsys/pkg/BILLS-105hr2015enr/pdf/BILLS-105hr2015enr.pdf>.

<sup>6</sup> The Henry J. Kaiser Family Foundation, Medicare Advantage Enrollees as a Percent of Total Medicare Population, <http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population>.

<sup>7</sup> Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, available at <https://www.gpo.gov/fdsys/pkg/PLAW-108publ173/pdf/PLAW-108publ173.pdf>.

<sup>8</sup> The Henry J. Kaiser Family Foundation, Medicare Advantage Enrollees as a Percent of Total Medicare Population, <http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population>.

based Incentive Payment system.<sup>9</sup> In addition, the CMS Innovation Center is actively working on a plan to use Medicare Supplement for managing the care provided by Traditional Medicare. These changes narrow the differences that exist between Medicare Advantage and Traditional Medicare, which will increase the likelihood that a Medicare Advantage enrollee will transition to Traditional Medicare and increase the competition between Medicare Advantage and Traditional Medicare.

(e) The Consumer Experience. When shopping for coverage on Medicare.gov, consumers are provided with a direct comparison of Medicare Advantage plans and Traditional Medicare. This juxtaposition on the CMS website demonstrates that Traditional Medicare provides a competitive restraint on Medicare Advantage by requiring that Medicare Advantage plans provide more value than Traditional Medicare.

21. The impact of the acquisition in the markets considered is a matter of the degree to which the already existing conditions for the ability of market power to be exercised is enhanced and not where the acquisition would create the opportunity for the exercise of market power where it did not previously exist. The proposed acquisition would result in some increase in the degree of concentration that would be viewed as meaningful in markets and regions. However, the OFFICE did not find strong evidence of an overall significant reduction in the competitive landscape of the private Florida health insurance markets resulting from the proposed acquisition.

22. The OFFICE has determined that a mechanism to ameliorate the increases in market concentration is necessary and appropriate as a condition of approval of the acquisition. With respect to decreasing market concentration, the OFFICE has considered the option of

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<sup>9</sup> Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, available at <https://www.congress.gov/bill/114th-congress/house-bill/2>.

divestiture of policies or affiliates, or some combination thereof. The OFFICE finds that such option is not in the best interest of the policyholders in the state of Florida as it may be disruptive to policyholders and also may be short term in nature. Divestiture may force policyholders to replace their chosen providers in order to remain in-network and may also result in unwanted changes in quality of services, benefits, and the cost-sharing structure of their plan. In addition, the fact that policyholders have the option to elect a different company every year may lessen the effectiveness of divestitures as a means to manage market concentration. As a result, the OFFICE has determined that requiring the APPLICANT to expand its product portfolio into currently underserved areas of Florida is a more effective means for reducing concentration. As outlined in paragraph twenty-four (24) below, the APPLICANT will expand its Individual Health Insurance Exchange portfolio in Florida.

23. Based on the Application, including the public hearing record, the OFFICE's analysis, and the specific requirements of this Consent Order, the OFFICE finds that the proposed acquisition is not likely to be hazardous or prejudicial to the insureds of the insurer or the public and that the acquisition would not substantially lessen competition in insurance in this state or tend to create a monopoly therein.

#### IV. CONDITIONS OF APPROVAL OF PROPOSED ACQUISITION

24. APPLICANT agrees to expand its Florida Individual Health Insurance Exchange portfolio as follows:

(a) By January 1, 2018, through Florida affiliates, APPLICANT will enter into five (5) new counties not in its 2016 Florida Individual Health Insurance Exchange portfolio.

(b) By January 1, 2020, APPLICANT will provide the OFFICE with a market analysis of exchange counties not in its 2018 Florida Individual Health Insurance

Exchange portfolio and use it to develop a plan to enter into these markets if APPLICANT can secure a competitive position based upon adequate premium rates; enter into satisfactory contracts with a sufficient number of providers to meet network adequacy standards in each county reviewed; and other competitive factors, some of which may be related to federal exchange policies.

(c) APPLICANT and the OFFICE agree to renegotiate the commitments to expand the Florida Individual Health Insurance Exchange portfolio contained in subparagraphs (a) and (b) above if both parties agree that there are material changes in the Federal Health Insurance Exchange program, including any material changes in subsidies.

25. APPLICANT has represented in its Application that certain efficiencies will be achieved as a result of the proposed transaction. As such, APPLICANT shall provide to the OFFICE annually, and for the first three (3) years following the closing of the transaction, documentation detailing the realization of estimated efficiencies. Said documentation should be included as a separate exhibit in the annual financial statement filings of the FLORIDA DOMESTICS.

26. APPLICANT agrees that all Health Maintenance Organizations with a Certificate of Authority issued under Part I of Chapter 641, Florida Statutes, that qualify as an "affiliate" as defined in Section 641.19, Florida Statutes, will comply with the Risk Based Capital requirements described in Section 624.4085, Florida Statutes. Further, use of the term "control" or "controlled" in Section 641.19, Florida Statutes, shall have the same meaning as defined in Section 624.10(3), Florida Statutes.

27. APPLICANT agrees that the process or a substantially similar process for developing the HIV/AIDS drugs formulary currently in use by the APPLICANT shall be utilized by all applicable affiliates of APPLICANT following the closing of the transaction.

28. APPLICANT agrees that APPLICANT and its affiliates transacting insurance in the state of Florida, which would include the FLORIDA DOMESTICS following closing of the acquisition, will cooperate with financial and market conduct examinations conducted by the OFFICE and make their accounts, records, documents, files, information, assets, and matters in their possession or control freely available to the OFFICE, its examiners, or its investigators, in accordance with Sections 624.318, 636.039, and 641.27, Florida Statutes.

#### V. OTHER CONDITIONS OF APPROVAL

29. APPLICANT has made material representations that, except as disclosed in the Application, none of the officers and directors of APPLICANT and none of the post-acquisition officers and directors of the FLORIDA DOMESTICS have been found guilty of, or pleaded guilty or nolo contendere to, a felony or a misdemeanor other than a minor traffic violation without regard to whether a judgment or conviction was entered by the court.

30. APPLICANT and FLORIDA DOMESTICS represent that they have submitted complete background information on each of the individuals described in paragraph twenty-nine (29) above. If said information has not been provided, or if the sources utilized by the OFFICE in its investigation process reveal that the representations made in paragraph twenty-nine (29) above are inaccurate, any such individual shall be removed as an officer or director within thirty (30) days of receipt of notification from the OFFICE and replaced with a person or persons acceptable to the OFFICE.

31. If upon receipt of such notification from the OFFICE, pursuant to paragraph thirty (30) above, APPLICANT or FLORIDA DOMESTICS do not timely take the required corrective

action, APPLICANT and FLORIDA DOMESTICS agree that such failure to act would constitute an immediate serious danger to the public and the OFFICE may immediately suspend, revoke, or take other administrative action as the OFFICE deems appropriate upon the Certificate of Authority of the FLORIDA DOMESTICS without further proceedings, pursuant to Sections 120.569(2)(n) and 120.60(6), Florida Statutes.

32. The Application represents there are no present plans or proposals to make any substantive changes to the Plan of Operation of the FLORIDA DOMESTICS. Prior written approval must be secured from the OFFICE prior to any material deviation from said Plan of Operation.

33. APPLICANT represents that, except as described in the Application, there are no present plans or proposals to make any substantive changes to the FLORIDA DOMESTICS, including liquidating them, selling any of their assets (except for transactions such as investment portfolio transactions in the ordinary course of business), merging or consolidating with any person or persons, or making any other major change in the business operations of the FLORIDA DOMESTICS.

34. APPLICANT agrees to immediately notify the OFFICE of any amendments to the Merger Agreement and file such amendments with the OFFICE within ten (10) days of the change. Further, should the U.S. Department of Justice impose any final written requirements upon the APPLICANT in regards to the proposed transaction, APPLICANT shall notify the OFFICE within three (3) business days.

35. APPLICANT or FLORIDA DOMESTICS shall submit to the OFFICE a copy of any filings submitted to the U.S. Securities and Exchange Commission regarding any lawsuits

relating to the transactions contemplated in the Merger Agreement, within fifteen (15) days of submission of the same to the U.S. Securities and Exchange Commission.

36. The parties to this Consent Order acknowledge that the consummation of the acquisition described herein is subject to obtaining appropriate regulatory approvals, including various state and federal agencies, in addition to satisfying other terms and conditions of the Merger Agreement. Accordingly, should such required approvals not be received, the provisions of this Consent Order shall terminate automatically and have no effect.

37. The U.S. Department of Justice and Florida Office of the Attorney General continue to independently investigate the proposed transaction under the standards applicable to their respective reviews. Any approval granted by this Consent Order shall not be acted upon until the expiration or termination of the applicable waiting periods under the Hart-Scott Rodino Antitrust Improvements Act of 1976, as amended.

38. Within ten (10) days of closing of the acquisition, APPLICANT or FLORIDA DOMESTICS shall provide to the OFFICE final executed closing documents and final executed copies of all related agreements. Should closing not occur, APPLICANT shall notify the OFFICE within three (3) business days.

39. HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC., HUMANA MEDICAL PLAN, INC., and CAREPLUS HEALTH PLANS, INC. shall, no later than fifteen (15) days after the month in which the transaction occurs, file an update to their Holding Company Registration Statement, as required by Section 628.801, Florida Statutes, and Rule 69O-143.046, Florida Administrative Code.

40. FLORIDA DOMESTICS shall submit to the OFFICE, within fifteen (15) days of closing of the acquisition, the newly assigned National Association of Insurance Commissioners company group code.

41. APPLICANT agrees that it shall make all necessary funds available to maintain the FLORIDA DOMESTICS in compliance with the surplus requirements of Sections 624.408, 636.045, and 641.225, Florida Statutes. APPLICANT and the FLORIDA DOMESTICS agree that failure to maintain compliance at all times with the capital and surplus requirements would constitute an immediate serious danger to the public and the OFFICE may immediately suspend, revoke, or take other administrative action as it deems appropriate upon the Certificate of Authority of the FLORIDA DOMESTICS without further proceedings, pursuant to Section 120.569(2)(n) and 120.60(6), Florida Statutes.

42. APPLICANT shall cause the Enterprise Risk Report required by Section 628.801(2), Florida Statutes, and any and all information necessary to evaluate the enterprise risks of HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC., HUMANA MEDICAL PLAN, INC., and CAREPLUS HEALTH PLANS, INC. to be furnished to the OFFICE pursuant to Section 628.461(3)(f)-(g), Florida Statutes.

43. APPLICANT represents that there are no agreements, written or oral, related to the management of the FLORIDA DOMESTICS that have not been provided to the OFFICE.

44. APPLICANT acknowledges that any amounts due to any of APPLICANT's affiliates transacting insurance in the state of Florida from a Management Service Organization as part of a risk sharing arrangement are considered as non-admitted assets when determining compliance with solvency requirements under the Florida Insurance Code.

45. APPLICANT and its affiliates domiciled in Florida shall not enter into any reinsurance or brokerage agreement, whether or not affiliated, that requires approval from the reinsurer or broker regarding any potential sale of its affiliates domiciled in Florida.

46. APPLICANT or its affiliates domiciled in Florida shall notify the OFFICE within ten (10) business days of any breach of, non-performance of, or default under any servicing agreement with affiliates or third party vendors providing services directly or indirectly to one or more of the affiliates domiciled in Florida that could result in or cause a material adverse change in the financial condition, business, performance, operations, or property of one or more of the affiliates domiciled in Florida.

47. Any time that one or more of the FLORIDA DOMESTICS are named as a party defendant in a class action lawsuit, the FLORIDA DOMESTICS so named shall report to the OFFICE, Life and Health Financial Oversight, within fifteen (15) days after the class is certified. The one or more FLORIDA DOMESTICS so named shall include a copy of the complaint at the time it reports the class action lawsuit to the OFFICE.

48. APPLICANT shall maintain and adhere to procedures necessary to detect and prevent prohibited transactions with individuals and entities that have been identified at the Treasury Department's Office of Foreign Assets Control website, <http://www.treas.gov/ofac>.

49. APPLICANT affirms and represents that all information, representations, documents, explanations, and statements provided to the OFFICE as part of this Application process fully describe all material agreements and understandings with regard to the acquisition and future operations of the FLORIDA DOMESTICS. APPLICANT further agrees and affirms that said information, representations, documents, explanations, and statements are material to

the issuance of this Consent Order and have been relied upon by the OFFICE in its determination to enter into this Consent Order.

50. Within sixty (60) days from the date of the closing of the transaction, APPLICANT shall furnish to the OFFICE a certification evidencing compliance with all of the requirements of this Consent Order. Any exceptions shall be so noted and contained in the certification. Exceptions noted in the certification shall also include a timeline defining when the outstanding requirements of the Consent Order will be complete. Said certification shall be submitted to the OFFICE via electronic mail and directed to the attention of the Assistant General Counsel representing the OFFICE in this matter and as named in this Consent Order.

51. The deadlines set forth in this Consent Order may be extended by written approval of the OFFICE. Additionally, reporting requirements and any other provision or requirement set forth in this Consent Order may be altered or terminated by written approval of the OFFICE. Approval of any deadline extension is subject to statutory and administrative regulation limitations.

52. Any prior Orders or Consent Orders that the FLORIDA DOMESTICS have entered into with the OFFICE prior to the closing of the acquisition shall apply and remain in full force and effect for the FLORIDA DOMESTICS, except where provisions of such Orders or Consent Orders have expired, have been superseded by subsequent Orders or Consent Orders, or are inconsistent with this Consent Order.

53. APPLICANT, HUMANA, and FLORIDA DOMESTICS expressly waive a hearing in this matter and the making of Findings of Fact and Conclusions of Law by the OFFICE and all further and other proceedings herein to which the parties may be entitled by law or rules of the OFFICE. APPLICANT, HUMANA, and FLORIDA DOMESTICS hereby

knowingly and voluntarily waive all rights to challenge or to contest this Consent Order, in any forum now or in the future available, including the rights to any administrative proceeding, circuit or federal court action, or any appeal.

54. APPLICANT and FLORIDA DOMESTICS agree that failure to adhere to one or more of the terms and conditions contained herein may result in the OFFICE revoking, suspending, or taking other action as the OFFICE deems appropriate upon one or more of the FLORIDA DOMESTICS' Certificate of Authority in the state of Florida.

55. Each party to this action shall bear its own costs and fees.

56. The parties agree that this Consent Order shall be deemed to be executed when the OFFICE has executed a copy of this Consent Order bearing the signatures of APPLICANT, HUMANA, and the FLORIDA DOMESTICS, or their authorized representative(s), notwithstanding the fact that the copy may have been transmitted to the OFFICE electronically. Further, APPLICANT, HUMANA, and the FLORIDA DOMESTICS agree that their signatures or the signatures of their representative(s) as affixed to this Consent Order shall be under the seal of a Notary Public.

WHEREFORE, subject to the terms and conditions set forth above, the Application by AETNA INC. to indirectly acquire one hundred percent (100%) of the issued and outstanding voting securities of HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC., HUMANA MEDICAL PLAN, INC., CAREPLUS HEALTH PLANS, INC., and COMPBENEFITS COMPANY is hereby APPROVED.

FURTHER, all terms and conditions contained herein are hereby ORDERED.

DONE and ORDERED this 15<sup>th</sup> day of February, 2016.



Kevin M. McCarty, Commissioner  
Office of Insurance Regulation

By execution hereof, AETNA INC. consents to entry of this Consent Order, agrees without reservation to all of the above terms and conditions and shall be bound by all provisions herein. The undersigned represents that he or she has the authority to bind AETNA INC. to the terms and conditions of this Consent Order.

[Corporate Seal]

AETNA INC.

By: 

Print Name: Gregory Martino

Title: Assistant Vice President

Date: 2/11/2016

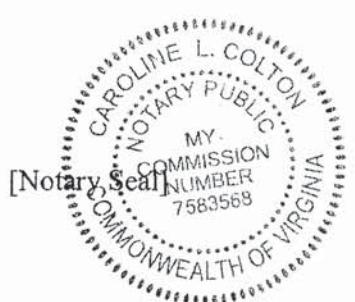
STATE OF Virginia

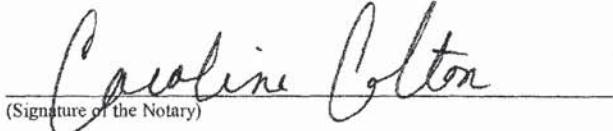
COUNTY OF Richmond  
City

The foregoing instrument was acknowledged before me this 11<sup>th</sup> day of February 2016,

by Gregory Martino as Assistant Vice President  
(name of person) (type of authority; e.g., officer, trustee, attorney in fact)

for Aetna, Inc.  
(company name)



  
(Signature of the Notary)

  
(Print, Type, or Stamp Commissioned Name of Notary)

Commission expires: 03/31/2018

Personally Known \_\_\_\_\_ OR Produced Identification

Type of Identification Produced Driver's License

My Commission Expires 03/31/2018

By execution hereof, HUMANA INC. consents to entry of this Consent Order, agrees without reservation to all of the above terms and conditions and shall be bound by all provisions herein. The undersigned represents that he or she has the authority to bind HUMANA INC. to the terms and conditions of this Consent Order.



HUMANA INC.

By: 

Print Name: Joseph C. Ventura

[Corporate Seal]

Title: Associate General Counsel & Assistant Corporate Secretary

Date: February 11, 2016

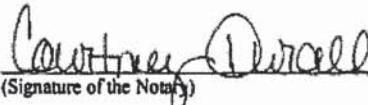
STATE OF KENTUCKY

COUNTY OF JEFFERSON

The foregoing instrument was acknowledged before me this 11th day of February 2016,

by Joseph C. Ventura as officer  
(name of person) (type of authority; e.g., officer, trustee, attorney in fact)

for Humana Inc.  
(company name)

  
(Signature of the Notary)



Courtney Durall #497215

(Print, Type, or Stamp Commissioned Name of Notary)

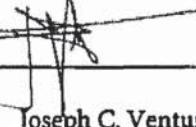
Personally Known X OR Produced Identification \_\_\_\_\_

Type of Identification Produced \_\_\_\_\_

My Commission Expires September 16, 2017

By execution hereof, HUMANA MEDICAL PLAN, INC., consents to entry of this Consent Order, agrees without reservation to all of the above terms and conditions and shall be bound by all provisions herein. The undersigned represents that he or she has the authority to bind HUMANA MEDICAL PLAN, INC., to the terms and conditions of this Consent Order.

HUMANA MEDICAL PLAN, INC.

By: 

Print Name: Joseph C. Ventura

Title: Assistant Corporate Secretary

Date: February 11, 2016

[Corporate Seal]

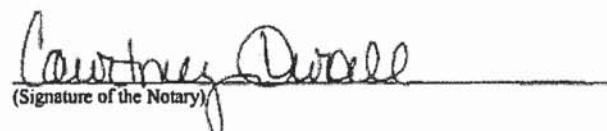
STATE OF KENTUCKY

COUNTY OF JEFFERSON

The foregoing instrument was acknowledged before me this 11th day of February 2016,

by Joseph C. Ventura as officer  
(name of person) (type of authority; e.g., officer, trustee, attorney in fact)

for Humana Medical Plan, Inc.  
(company name)

  
(Signature of the Notary)



COURTNEY DURALL  
STATE AT LARGE  
NOTARY PUBLIC  
KENTUCKY  
MY COMMISSION EXPIRES SEPT. 16, 2017

Courtney Durall #497215

(Print, Type, or Stamp Commissioned Name of Notary)

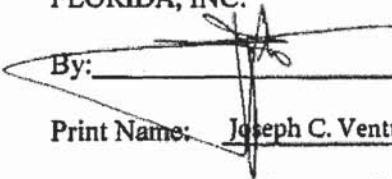
Personally Known  OR Produced Identification \_\_\_\_\_

Type of Identification Produced \_\_\_\_\_

My Commission Expires September 16, 2017

By execution hereof, HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC. consents to entry of this Consent Order, agrees without reservation to all of the above terms and conditions and shall be bound by all provisions herein. The undersigned represents that he or she has the authority to bind HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC. to the terms and conditions of this Consent Order.

HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.

By: 

Print Name: Joseph C. Ventura

Title: Assistant Corporate Secretary

Date: February 11, 2016

[Corporate Seal]

STATE OF KENTUCKY

COUNTY OF JEFFERSON

The foregoing instrument was acknowledged before me this 11th day of February 2016,

by Joseph C. Ventura as officer  
(name of person) (type of authority; e.g., officer, trustee, attorney in fact)

for Humana Health Insurance Company of Florida, Inc.  
(company name)



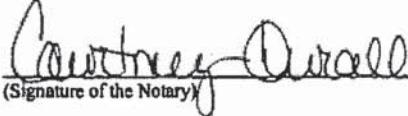
COURTNEY DURALL

STATE AT LARGE

KENTUCKY

MY COMMISSION EXPIRES SEPT 16, 2017

(Signature of the Notary)



Courtney Durall #497215

(Print, Type, or Stamp Commissioned Name of Notary)

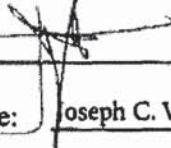
Personally Known  OR Produced Identification \_\_\_\_\_

Type of Identification Produced \_\_\_\_\_

My Commission Expires September 16, 2017

By execution hereof, CAREPLUS HEALTH PLANS, INC. consents to entry of this Consent Order, agrees without reservation to all of the above terms and conditions and shall be bound by all provisions herein. The undersigned represents that he or she has the authority to bind CAREPLUS HEALTH PLANS, INC. to the terms and conditions of this Consent Order.

CAREPLUS HEALTH PLANS, INC.

By: 

Print Name: Joseph C. Ventura

Title: Assistant Corporate Secretary

Date: February 11, 2016

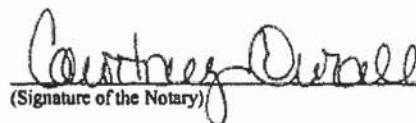
[Corporate Seal]

STATE OF KENTUCKY

COUNTY OF JEFFERSON

The foregoing instrument was acknowledged before me this 11th day of February 2016,

by Joseph C. Ventura as Officer  
(name of person) (type of authority, e.g., officer, trustee, attorney in fact)  
for CarePlus Health Plans, Inc.  
(company name)

  
(Signature of the Notary)



COURTNEY DURALL  
NOTARY PUBLIC  
STATE AT LARGE  
Notary Seal KENTUCKY  
MY COMMISSION EXPIRES SEPT. 16, 2017

Courtney Durall #497215

(Print, Type, or Stamp Commissioned Name of Notary)

Personally Known X OR Produced Identification \_\_\_\_\_

Type of Identification Produced \_\_\_\_\_

My Commission Expires September 16, 2017

By execution hereof, COMPBENEFITS COMPANY, consents to entry of this Consent Order, agrees without reservation to all of the above terms and conditions and shall be bound by all provisions herein. The undersigned represents that he or she has the authority to bind COMPBENEFITS COMPANY, to the terms and conditions of this Consent Order.



[Corporate Seal]

COMPBENEFITS COMPANY

By: 

Print Name: Joseph C. Ventura

Title: Assistant Corporate Secretary

Date: February 11, 2016

STATE OF KENTUCKY

COUNTY OF JEFFERSON

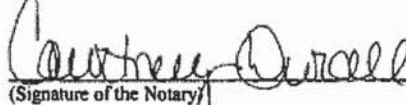
The foregoing instrument was acknowledged before me this 11th day of February 2016,

by Joseph C. Ventura as officer  
(name of person) (type of authority, e.g., officer, trustee, attorney in fact)  
for CompBenefits Company.  
(company name)



COURTNEY DURALL  
STATE AT LARGE

Notary Seal KENTUCKY  
MY COMMISSION EXPIRES SEPT 16, 2017



(Signature of the Notary)

Courtney Durall #497215  
(Print, Type, or Stamp Commissioned Name of Notary)

Personally Known X OR Produced Identification \_\_\_\_\_

Type of Identification Produced \_\_\_\_\_

My Commission Expires September 16, 2017

COPIES FURNISHED TO:

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E-Mail: [Alyssa.Lathrop@floir.com](mailto:Alyssa.Lathrop@floir.com)

**STATEMENT**  
**of the**  
**American Medical Association,  
Florida Medical Association, Inc. and the  
Florida Osteopathic Medical Association**  
**to the**  
**Office of Insurance Regulation  
Florida Department of Financial Services**

**RE: Aetna Application for the Proposed Acquisition of Humana**

**December 17, 2015**

The American Medical Association (AMA), Florida Medical Association (FMA) and Florida Osteopathic Medical Association (FOMA) appreciate the opportunity to provide comments regarding Aetna, Inc. (Aetna) application for the proposed acquisition of Humana, Inc. (Humana). We believe that high insurance market concentration is an important issue of public policy because the anticompetitive effects of insurers' exercise of market power poses a substantial risk of harm to consumers. Our analysis of data related to the proposed merger reveals significant concerns with respect to the impact on consumers in terms of health care access, quality, and affordability.

We have analyzed the likely competitive effects of this proposed merger both in the sell-side market for insurance and the buy-side market for physician services. We have considered data on competition in health insurance in recent studies on the effects of health insurance mergers, and the testimony of Aetna's executives and expert, Thomas R. McCarthy PhD of NERA Economic Consulting.

We have reviewed this matter from our long-standing perspective that competition in health insurance, not consolidation, is the right prescription for health insurer markets. Competition will lower premiums, force insurers to enhance customer service, pay bills accurately and on time, and develop and implement innovative ways to improve quality while lowering costs. Competition also allows physicians to bargain for contract terms that touch all aspects of patient care.

We have concluded that this merger will likely impair access, affordability, and innovation in the sell-side market for health insurance, and on the buy side, will deprive physicians of the ability to negotiate competitive health insurer contract terms. The result will be detrimental to consumers. "If past is prologue," notes Northwestern University Professor Leemore S. Dafny, PhD "insurance consolidation will tend to lead to lower payments to healthcare providers, but those lower payments will not be passed on to consumers. On the contrary, consumers can expect

higher insurance premiums.”<sup>1</sup> Therefore, Aetna has not carried *its* “burden of proof” that the effect of the acquisition would *not* substantially lessen competition in the line of insurance for which the specialty insurer is licensed or certified in the state or would not tend to create a monopoly therein.”<sup>2</sup> Accordingly, Aetna’s application to acquire Humana should be denied or, in the alternative, the Office of Insurance Regulation (OIR) should continue the hearing giving interested parties a meaningful opportunity to be heard.

## PROCEDURAL BACKGROUND AND REQUEST THAT HEARING REMAIN OPEN

On November 20, OIR published in the Florida Register a notice of a public hearing on Aetna’s application for the proposed acquisition of Humana. Although physicians practicing in the state of Florida have substantial interests that would be affected by OIR’s decision on the application, the OIR did not serve a copy of the notice on the FMA or FOMA. Moreover, the Florida Register notice was published on the Friday before Thanksgiving and the hearing date set for December 7—notification and scheduling that made it both unlikely for those affected by the decision to timely learn of the hearing and to prepare to participate. In addition, a submission of comments by December 17 has been hampered because OIR has been dilatory in producing requested application-related documents such as Aetna’s competitive analysis (which the OIR still has not produced).

A report of the hearing by *Politico Florida* describes the OIR hearing as oddly lacking the participation of anyone except “Aetna and Humana executives and witnesses for the companies”—a hearing best characterized as a mere gesture inconsistent with the important public policy issues at stake. She writes:

Both the American Medical Association and the American Hospital Association have urged federal antitrust regulators to halt the planned merger, saying it would reduce competition and limit patient’s access to quality, affordable healthcare.

But at the capital on Monday, no critics appeared to oppose the merger, which would impact about 2.4 million people spanning four licensed Humana insurance companies in Florida.

Instead, a panel of the office of insurance regulation... heard testimony from a handful of Aetna and Humana executives and witnesses for the companies.<sup>3</sup>

Aetna has said that it does not expect the acquisition, if approved, to be closed any earlier than mid-2016. Accordingly, a 30-day continuation of the hearing to allow critics of the proposed merger to have timely access to documents and to testify before the hearing panel could be

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<sup>1</sup> See Dafny, “Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?”, Testimony before the Senate Committee on the Judiciary, September 22, 2015, at 10.

<sup>2</sup> Section 628.4615 (8) and Section 628.465 (8) (j), Florida statutes.

<sup>3</sup> See *No critics show up for hearing on proposed Aetna-Humana merger*, available at <http://politi.co/1IQYQLq>

granted at little or no inconvenience to Aetna /Humana. We respectfully request that continuance and opportunity to be heard.

## LEGAL STANDARD

Florida law places the “burden of proof” upon Aetna to prove that “the effect of the acquisition” would “not substantially lessen competition” or “would not tend to create a monopoly.”<sup>4</sup> In other words, Aetna must produce the evidence and carry *its* burden of persuasion that the merger would not substantially lessen competition. Accordingly, this statement will begin by examining the evidence presented by Aetna through its expert, Dr. McCarthy.

## THE HEALTH INSURER MERGER WOULD CREATE, ENHANCE OR ENTRENCH MARKET POWER IN THE SALE OF HEALTH INSURANCE

### *Commercial Health Insurance*

Competition is likely to be greatest when there are many sellers, none of which have any significant market share. When there are a few firms with large shares of a market, the elimination of a competitor may create opportunities for the remaining firms to engage in coordinated interaction, including express or tacit collusion or oligopolistic behavior. For this reason the 2010 Federal Trade Commission (FTC) and Department of Justice (DOJ) Horizontal Merger Guidelines (“Horizontal Merger Guidelines”) and the 2015 National Association of Insurance Commissioners Model Insurance Holding Company System Regulating Act (“NAIC Competitive Standard”) are directed at preventing mergers that significantly increase the concentration of firms in concentrated markets. Oddly, Dr. McCarthy’s competitive effect testimony omits any discussion of market concentration and its increase.

### Merger Violates NAIC Competitive Standard

However, health insurer commercial insurance market shares reported by Dr. McCarthy in his Table 1 reveal a Florida statewide market that is highly concentrated under the NAIC Competitive Standard that Dr. McCarthy himself, within another context, employs in his analysis. That standard looks at the “four-firm concentration ratio” (CR 4) to determine the degree of danger to competition in a particular market. Under those standards, a highly concentrated market is one in which the shares of the four largest insurers is 75% or more of the market. According to the shares presented in Dr. McCarthy’s Table 1, the shares of the four largest commercial health insurers total 78.8%. In such a highly concentrated market, there is a *prima facie* violation of the NAIC Competitive Standard when a firm with a 10% market share merges with a firm with a 2% or more market share.

Such a *prima facie* violation of the NAIC Competitive Standard occurs in the case of the proposed merger because, according to Dr. McCarthy, Aetna has more than a 10% market share (13.6%, according to Dr. McCarthy) and Humana’s market share is more than 2% (5.7%,

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<sup>4</sup> Section 628.4615 (8) and Section 628.465 (8) (j), Florida Statutes.

according to Dr. McCarthy). See McCarthy Table 1. Therefore, far from describing an Aetna/Humana merger that would allow it to carry the burden of proving that the merger does *not* substantially lessen competition, Dr. McCarthy's table describes the opposite—a merger that is *prima facie* anticompetitive.

Moreover, Dr. McCarthy made no effort to rebut the *prima facie* violation of the NAIC Competitive Standard in commercial health insurance. For example, a *prima facie* violation of the NAIC Competitive Standard could hypothetically be rebutted by establishing ease of entry into the Florida commercial health insurance market. However, Dr. McCarthy's entire discussion of entry is directed at the market for individually underwritten plans where he concedes that the merger would give the parties a troubling market share and he engages in speculation that at some future date there will be net entry. (More on that later.) Therefore, Aetna's application to acquire Humana cannot be approved under the Florida legal standard.

#### Merger Violates Federal Antitrust Merger Enforcement Standards

The result is no different if we consider the competitive effect of the merger under the Horizontal Merger Guidelines. The DOJ defines relevant health insurance markets as local rather than statewide in health insurer merger cases. This position should not be controversial in this matter since Aetna witnesses testified that health insurance markets are local.<sup>5</sup> Utilizing data obtained from HealthLeaders-Interstudy Managed Market Surveyor from January 1, 2013, the AMA has determined the commercial health insurance market concentrations and change in market concentrations that would result from the merger in metropolitan statistical areas within the state of Florida.<sup>6</sup>

The AMA analysis shows the proposed Aetna acquisition of Humana would be presumed likely, under the Horizontal Merger Guidelines, to enhance market power in the Jacksonville, Florida, Metropolitan Statistical Area (MSA) where the post-merger Herfindahl-Hirschman Index (HHI) of market concentration would be 2592 (meaning "highly concentrated") and the increase in the HHI would be 289 points. Similarly, the merger would be presumed likely to enhance market power both in the Sarasota-Bradenton-Venice MSA (post-merger HHI of 2723 and an HHI increase of 260) and in the Tampa-St. Petersburg-Clearwater MSA (post-merger HHI of 2576 and an increase of 204 points). There are also additional heavily populated MSAs where under the Horizontal Merger Guidelines, the Aetna/Humana merger potentially raises significant competitive concerns. They include: Fort Lauderdale-Pompano Beach-Deerfield Beach,

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<sup>5</sup> The local nature of health care delivery and the marketing and other business practices of health insurers strongly suggest that health insurance markets are local. Consumers buy coverage that serves them close to where they work and live. See US Senate testimony of Professor Leemore Dafny at <http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf>

<sup>6</sup> Following the example of DOJ, the AMA has measured market concentration by using the Herfindahl-Hirschman Index (HHI) instead of the CR4. The HHI is the sum of the squares of the market shares of every firm in the relevant market. Markets with HHIs less than 1500 are characterized as unconcentrated. Those with HHIs between 1500 and 2500 are moderately concentrated, and those with HHIs more than 2500 are highly concentrated. Mergers in moderately concentrated markets that change the HHI by more than 100 are deemed by the merger guidelines to potentially raise significant competitive concerns and often warrant scrutiny. Mergers in highly concentrated markets that raise the HHI more than 200 are presumed likely to enhance market power.

Lakeland-Winter Haven, Miami-Miami Beach-Kendall, and West Palm Beach-Boca Raton-Boynton Beach.

In sum, under the Horizontal Merger Guidelines, the merger would create market structures that would facilitate express or tacit collusion or oligopolistic behavior and would therefore substantially lessen competition. Because Dr. McCarthy did not address this issue, Aetna has not met its burden of proof to show that the merger would not substantially lessen competition or tend to create a monopoly in commercial health insurance within the state of Florida. Consequently, the merger must not be approved.

#### *Florida Commercial Enrollment—Individually Underwritten Plans*

While we have already established that the merger must not be approved because of its effect in the commercial insurance market, Dr. McCarthy has chosen to do an analysis of what he claims to be a market for “individually underwritten plans,” and so we will here assume a market for commercial insurance plans sold to individuals.

#### Merger Violates NAIC Competitive Standard

In his testimony, Dr. McCarthy concedes that the Aetna/Humana 37.7% combined share of individually underwritten plans raises the specter of a merged firm that might unilaterally exercise market power. (Dr. McCarthy testified that 30% is the threshold for when a merger raises antitrust concerns.) However he continues to ignore the market concentration and oligopolistic concerns also raised by the merger. The share of the four largest insurers of individually underwritten plans exceeds the NAIC’s Competitive Standard threshold of 75% (it is 83.7%) such that it too is “highly concentrated.” (By comparison, the four-firm concentration ratio for domestic airlines is 62%.)<sup>7</sup> There is *prima facie* evidence of a violation of the Competitive Standard because Aetna has more than a 10% share (it is 20.3%) and Humana has more than 2% (it is 17.3%).

#### Merger Violates Federal Antitrust Merger Enforcement Standards

We have also analyzed the merger under the lens of the Horizontal Merger Guidelines. The post-merger HHI is more than 2500 (it is 3053), meaning that the market would become highly concentrated. Because the change in the HHI is more than 200 (it is 705), the merger under the federal guidelines is presumed likely to be anticompetitive.

#### The Loss of Competition Would Be Durable Regardless of the Insurance Exchange

The insurance exchange (now called the “health insurance marketplace”) is no cure for reversing the lack of choice that would occur in many Florida markets if the proposed merger were approved. Insurer participation in healthcare.gov 2015-2016 has not been encouraging in

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<sup>7</sup> U.S. Department of Transportation Bureau of Transportation Statistics, “Airline Domestic Market Share July 2014-June 2015,” available at <http://www.transstats.bts.gov/>.

Florida. According to a Kaiser Family Foundation analysis of insurer participation in 2016 marketplaces, within 67 Florida counties the average number of insurers will be 2.6.<sup>8</sup> That is down from 3.8 in 2015, showing a substantial net exit from the market. Sixty-six percent of these 67 counties will have only one or two insurers. Even UnitedHealth Group Inc. with its brand name, provider networks, and Florida market share of 20.5% in commercial insurance is reportedly considering exiting the exchange.<sup>9</sup>

Given the high market share of a combined Aetna/Humana, the flunked NAIC four-firm concentration ratio standard, and the Kaiser study results for Florida documenting net exit from the marketplaces, allowing the merger of Aetna/Humana, two of the three largest competitors in individually underwritten plans, would result in a total collapse of competition. In any event, Aetna has not carried its burden of proof that the effect of the acquisition would not substantially lessen competition in the market for commercial insurance plans sold to individuals.

### *Medicare Advantage*

The merger would combine the largest insurer of Medicare Advantage (Humana) with the fourth largest (Aetna) to form a Medicare Advantage insurer with a 44% market share, a much higher share than the 30% threshold that Dr. McCarthy in his testimony concedes is associated with antitrust concerns.<sup>10</sup> Most troubling, however, is that the merger would further concentrate a market that is already highly concentrated among a small number of firms.<sup>11</sup>

### Merger Violates NAIC Competitive Standard

Under the NAIC Competitive Standard the Medicare Advantage market is highly concentrated. The total market share of the four largest firms in the market is 79%. Also there is *prima facie* evidence of a violation of the competitive standard because Humana has more than a 10% share (it is 37.4%) and Aetna has more than 2% (it is 6.1%).

When the Herfindahl–Hirschman Index of market concentration is used as in the Horizontal Merger Guidelines, the Aetna/Humana merger is shown to have a substantial anticompetitive impact on a staggering number of Florida counties. According to a market study employing the Horizontal Merger Guidelines and commissioned by the American Hospital Association (AHA), the merger is presumed to be anticompetitive (likely to enhance market power) in 44 Florida Medicare Advantage group plan markets (evaluated geographically as counties, following the DOJ practice which is to account for federal regulations). For individual Medicare Advantage

<sup>8</sup> See *Analysis of Insurer Participation in 2016 Marketplaces*. Kaiser Family Foundation at <http://kff.org/health-reform/issue-brief/analysis-of-insurer-participation-in-2016-marketplaces/>.

<sup>9</sup> *UnitedHealth may exit Obamacare individual exchange*. Reuters. See <http://www.reuters.com/article/us-unitedhealth-grp-outlook-idUSKCN0T81E020151119>.

<sup>10</sup> For a discussion of the dismal condition of competition in Medicare Advantage See: B. Biles, G. Casillas, and S. Guterman, *Competition Among Medicare's Private Health Plans: Does It Really Exist?* The Commonwealth Fund, August 2015; Gretchen Jacobson, Anthony Damico, and Marsha Gold, Kaiser Family Foundation Issue Brief, *Medicare Advantage 2015 Spotlight: Enrollment Market Update*, (June 30, 2015), Figure 1, available at: <http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/>.

<sup>11</sup> See McCarthy Table 6.

plans, the merger is presumptively anticompetitive in 13 counties that include over one-half million (564K) individual Medicare Advantage plan enrollees and include Broward.

#### Medicare Advantage Comprises a Product Market That Is Separate and Distinct from Traditional Medicare

Dr. McCarthy has argued that an insurer's share of the Medicare Advantage market is of no antitrust consequence given that consumers have the option of enrolling in traditional Medicare and therefore, in Aetna's view, traditional Medicare and Medicare Advantage plans are not separate product markets.<sup>12</sup> Dr. McCarthy contends that 21% of persons terminating Aetna Medicare Advantage turn to traditional Medicare. This contention however proves nothing about demand substitutability i.e., whether customers have an ability and willingness to substitute away from one product to another in response to a small but significant and non-transitory increase in the quality adjusted price of an Aetna product—the well-established way of determining whether markets are separate.<sup>13</sup> We do not know from Dr. McCarthy's testimony why these persons left Aetna and turned to traditional Medicare. At the extreme, the patients leaving Aetna and opting for traditional Medicare may have been forced to turn to traditional Medicare. Moreover, Dr. McCarthy does not explain why the overwhelming portion of those leaving Aetna's Medicare Advantage apparently stay with Medicare Advantage. One explanation is that traditional Medicare is not an adequate substitute for Medicare Advantage, absent extreme circumstances that may account for those who switch from Aetna to traditional Medicare.

There are many critically important differences between Medicare Advantage and traditional Medicare that explain why the proposed merger should be evaluated for its effects in the Medicare Advantage market separately. Medicare Advantage plans offer substantially richer benefits at lower costs than traditional Medicare.<sup>14</sup> Moreover, in Medicare Advantage plans seniors can receive a single plan covering a variety of benefits that seniors in traditional Medicare must assemble themselves. The combination of richer benefits and one stop shopping accounts for the strong preference by many seniors for Medicare Advantage plans. Accordingly, seniors are not likely to switch away from Medicare Advantage plans to traditional Medicare in sufficient numbers to make an anticompetitive price increase or reduction in quality unprofitable to a Medicare Advantage insurer.<sup>15</sup> The closest competition to one Medicare Advantage insurer's plan is another insurer's Medicare Advantage plan and the presence of many competing Medicare Advantage insurers is what keeps quality competitive. Consequently, the Medicare Advantage and traditional Medicare programs constitute separate and distinct product markets and the proposed mergers should be evaluated for their effects in a Medicare Advantage market.<sup>16</sup>

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<sup>12</sup> See also Bertolini, "Examining Consolidation in the Health Insurance Industry and its Impact on Consumers," Testimony before the Senate Committee on the Judiciary, September 22, 2015, at 5.

<sup>13</sup> See Horizontal Merger Guidelines, Section 4.

<sup>14</sup> See *U.S. v. UnitedHealth Group and Sierra Health Services Inc.*, Civil No1:08 –cu-00322 (DDC2008); United States v. Humana, No. 12-cv-00464 (D.D.C. Mar. 27, 2012), available at: [www.justice.gov/atr/cases/f281600/281618.pdf](http://www.justice.gov/atr/cases/f281600/281618.pdf).

<sup>15</sup> See competitive impact statement, *United States v. UnitedHealth*, supra, at 4-5.

<sup>16</sup> See *U.S. v. UnitedHealth Group and Sierra Health Services Inc.*, Civil No1:08 –cu-00322 (DDC2008) (the DOJ alleged that Medicare Advantage is a distinct market separate from the Medicare market and obtained a consent decree requiring the

Notably, the DOJ has defined a separate product market for Medicare Advantage plans.<sup>17</sup> The DOJ has, therefore, concluded that a small but significant increase in Medicare Advantage plan premiums or reduction in benefits was unlikely to cause a sufficient number of seniors to switch to traditional Medicare such that the price increase or reduction in benefits would be unprofitable.

#### ***BARRIERS TO ENTRY AND THE NEED TO PRESERVE POTENTIAL COMPETITION***

Dr. McCarthy contends that a merged Aetna/Humana could not exercise market power in the market for individually underwritten plans because of ease of entry. However, far from carrying his burden of proof, Dr. McCarthy's claim of ease of entry is belied on the face of his own Table 4. That table shows that from 2013 to 2014, the statewide market shares, ranking of market leaders, and number of competitors in the individually underwritten plans have remained mostly unchanged, with the exception of Humana and Aetna, which increased their shares but retained the same market leadership positions.

AMA's own analysis of MSA data from its *Competition in Health Insurance* studies show that in the numerous large MSAs where the merger would be anticompetitive in commercial markets, the market shares, ranking of market leaders and number of competitors have also been durable and little changed from 2010 thru 2013, the most recent timeframe for which we have data.

Rather than present data that demonstrates ease of entry, Dr. McCarthy substitutes speculation. He claims that Centene Corporation (Centene) a health insurer with a Florida presence in Medicaid long-term care will one day soon compete successfully on the insurance marketplace. However, Centene does not even appear to have a trivial market share in McCarthy's tables describing the present day Florida market for commercial insurance. Even assuming that Centene were to enter the market, it would be sheer speculation to assume that it could come close to replacing the competition lost by the merger of the second and third largest participants in the market for plans sold to individuals. Instead, the lost competition is likely to be permanent and acquired health insurer market power would be durable because barriers to entry prevent the higher profits often associated with concentrated markets from allowing new entrants to restore competitive pricing. These barriers include the need for sufficient business to permit the spreading of risk and contending with established insurance companies that have built long-term relationships with employers and other consumers.<sup>18</sup> In addition, a DOJ study of entry and

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divestiture of United's Medicare Advantage business in the Las Vegas area as a precondition to obtaining merger approval); *see also* Gretchen A. Jacobson, Patricia Neuman, Anthony Damico, "At Least Half Of New Medicare Advantage Enrollees Had Switched From Traditional Medicare During 2006–11," 34 *Health Affairs* (Millwood) 48, 51 (Jan. 2015), available at <http://content.healthaffairs.org/content/34/1/48.full.pdf>; R. Town and S. Liu (2003), "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* 34(4): 719-36; L.Dafny and D. Dranove (2008), "Do Report Cards Tell Consumers Anything They Don't Already Know?" *RAND Journal of Economics* 39.

<sup>17</sup> See, United States v. Humana, No. 12-cv-00464 (D.D.C. Mar. 27, 2012) (complaint ¶¶ 20-21) (avail. at <http://www.justice.gov/atr/case-document/file/499076/download>); United States v. UnitedHealth Grp. Inc. & Sierra Health Servs., Inc., No. 08-cv-00322 (D.D.C. Feb. 25, 2008) (complaint ¶¶ 15-18) (avail. at <http://www.justice.gov/atr/case-document/file/514126/download>).

<sup>18</sup> See Robert W. McCann, *Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field,"* Health Law Handbook (Thomson West 2007); Mark V. Pauly, *Competition in Health Insurance Markets*, 51 Law & Contemp. Probs. 237

expansion in the health insurance industry found that “brokers typically are reluctant to sell new health insurance plans, even if those plans have substantially reduced premiums, unless the plan has strong brand recognition or a good reputation in the geographic area where the broker operates.”<sup>19</sup>

Perhaps the greatest obstacle is the so-called chicken and egg problem of health insurer market entry: health insurer entrants need to attract customers with competitive premiums that can only be achieved by obtaining discounts from providers. However providers usually offer the best discounts to incumbent insurers with a significant business—volume discounting that reflects a reduction in transaction costs and greater budget certainty. Hence, incumbent insurers have a durable cost advantage.<sup>20</sup>

The presence of significant entry barriers in health insurance markets was demonstrated in the 2008 hearings before the Pennsylvania Insurance Department on the competition ramifications of the proposed merger between Highmark Inc. and Independence Blue Cross. In a report commissioned by the Pennsylvania Insurance Department, LECG Corporation, a global expert services and consulting firm (LECG) concluded that it was unlikely that any competitor would be able to step into the market after a Highmark/IBC merger:

[B]ased on our interviews of market participants and other evidence, there are a number of barriers to entry—including the provider cost advantage enjoyed by the dominant firms in those areas and the strength of the Blue brand in those areas.... On balance, the evidence suggests that to the extent the proposed consolidation reduces competition, it is unlikely that other health insurance firms will be able to step in and replace the loss in competition.<sup>21</sup>

Dr. McCarthy essentially argues that the health insurance marketplaces have made successful entry easy. The facts however do not bear out that claim. Recent developments only highlight the barrier to entry problem. Twelve of the 23 nonprofit insurance cooperatives, which were intended to inject competition into health insurance markets, have failed.<sup>22</sup> According to the Times, many Co-ops “appear to be scrambling to have enough money to cover claims as well as enroll new customers as they enter their third year.”<sup>23</sup> According to the *Washington Post* of October 10, nearly half of the 23 Affordable Care Act (ACA) insurance co-ops, subsidized by millions of dollars in government loans, have been told by federal regulators that their finances,

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(1988); Federal Trade Commission and U.S. Department of Justice, Improving Health Care: A Dose of Competition (July,2004); *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 Law & Contemp. Probs. 195 (1988).

<sup>19</sup> Sharis A. Pozen, Acting Assistant Att'y Gen., Dep't of Justice Antitrust Div., *Competition and Health Care: A Prescription for High-Quality, Affordable Care* 7 (Mar. 19, 2012) [hereinafter Pozen, *Competition and Health Care*], available at <http://www.justice.gov/atr/speech/competition-and-health-care-prescription-high-quality-affordable-care>.

<sup>20</sup> Id. at 7.

<sup>21</sup> LECG Inc., “Economic Analyses of the Competitive Impacts From The Proposed Consolidation of Highmark and IBC.” September 10 2008, Page 9.

<sup>22</sup> “Marco Rubio Quietly Undermines Affordable Care Act,” the New York Times, December 10, 2015.

<sup>23</sup> “Tough going for Co-ops,” the New York Times, September 15, 2015, available at

<http://www.nytimes.com/2015/09/16/business/health-cooperatives-find-the-going-tough.html?ref=health>.

enrollment, or business model need to “shape up.” The quick death of these co-ops illustrate that even with heavy federal subsidies, health insurance is a tough business to enter.

According to a recent *New York Times* article, the Obama administration will pay only 13% of what insurance companies were expecting to receive through “risk corridors” that were expected to help insurance companies with too many sick people and too little cash to operate in the first years under the health law.<sup>24</sup> As we mentioned earlier, there have been reports that UnitedHealth Group Inc. may leave the marketplaces. Moreover, only two for-profit companies that were not already health insurers, reports the *Times*, have entered the state marketplaces. One of them is Oscar, which was touted by Aetna’s CEO as an example of successful entry in his testimony before the Senate Judiciary Committee. However, according to the *Times*, Oscar estimated in a regulatory filing that it lost about \$27.5 million last year, roughly half of its 2014 revenue. The CEO of Oscar, one of the very few new companies to even attempt entry, described the task as “quite daunting.”<sup>25</sup> In any event, Dr. McCarthy’s speculation that a new successful entrant will emerge is not evidence and Aetna has not carried *its* burden of persuasion that the merger would not substantially lessen competition.

### *The Loss of Potential Competition*

One of the most important implications of the barriers to entry that persist with the advent of the marketplaces is the need to preserve the potential competition that would be lost if an incumbent insurer is acquired. Thus, when the largest insurer of Medicare Advantage (Humana) is acquired by the fourth-largest (Aetna) to form the largest Medicare Advantage insurer in Florida, the highly concentrated geographic markets where Humana faces little competition are deprived of their most likely entrant, Aetna. The foreclosure of this future market role serves to lessen competition. Professor Dafny expressed concern about this loss of potential competition in her Senate testimony: “[C]onsolidation even in non-overlapping markets reduces the number of potential entrants who might attempt to overcome price-increasing (or quality-reducing) consolidation in markets where they do not currently operate.”<sup>26</sup>

Commenting on the loss of potential competition that would accompany the proposed mergers, Professor Thomas L. Greaney, who is one of the country’s leading experts on antitrust in healthcare, observes:

An important issue... is whether the proposed mergers will lessen *potential competition* that was expected under the ACA (the potential entry by large insurers into each other’s markets, incidentally, was the argument advanced as to why a “public option” plan was unnecessary). At present all four of the merging companies compete on the exchanges and they overlap in a number of states. [Citation omitted]. Notably, prior to the announced mergers, these insurers appear to have been considering further expanding their footprint on

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<sup>24</sup> Supra, note 22

<sup>25</sup> This \$1.5 billion Startup is Making Health Insurance Suck Less, *Wired*, March, 20, 2015, available at <http://www.wired.com/2015/04/oscar-funding/>.

<sup>26</sup> Dafny, supra note 1, at 13.

the exchanges by entering a number of new states. [Citation omitted]. Thus reducing the array of formidable potential entrants into exchange markets from the “Big 5” to be “Remaining 3” will undermine the cost containment effects of competition in exchange markets. The lessons of oligopoly are pertinent here: consolidation that would pare the insurance sector down to less than a handful of players is likely to chill the enthusiasm for venturing into a neighbor’s market or engaging in risky innovation. One need look no further than the airline industry for a cautionary tale.<sup>27</sup>

#### THE MERGER WOULD CREATE, ENHANCE OR ENTRENCH MONOPSONY POWER IN FLORIDA MARKETS FOR THE PURCHASE OF PHYSICIAN SERVICES

Just as the merger would enhance market power on the selling side of the market, it would also enhance monopsony or buyer’s power in the purchase of inputs such as physician services, eviscerating physicians’ ability to contract with alternative insurers in the face of unfavorable contract terms and ultimately inefficiently reducing the quality or quantity of services that physicians are able to offer patients. As Professor Dafny explained in her recent Senate testimony on this merger: “Monopsony is the mirror image of monopoly; lower input prices are achieved by reducing the quantity or quality of services below the level that is socially optimal.”<sup>28</sup> She further explained that the “textbook monopsony scenario...pertains when there is a large buyer and fragmented suppliers.”<sup>29</sup> This characterizes the market in which dominant health insurers purchase the services of physicians who typically work in small practices with 10 or fewer physicians.<sup>30</sup>

Even in markets where the merged health insurer lacks monopoly or market power to raise premiums for patients, the insurer still may have the power to force down physician compensation levels, raising antitrust concerns. Thus, in the UnitedHealth Group Inc./PacifiCare merger, the DOJ required a divestiture based on monopsony concerns in Boulder, Colorado, even though the merged entity would not necessarily have had market power in the sale of health insurance. The reason is straightforward: the reduction in compensation would lead to diminished service and quality of care, which harms consumers even though the direct prices paid by subscribers do not increase.<sup>31</sup>

Moreover, the reduction in the number of health insurers would create health insurer oligopolies that, through coordinated interaction, can exercise buyer power. Indeed the setting of payment

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<sup>27</sup> Greaney, “The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act’s Impact on Competition,” Testimony before the House Committee on the Judiciary, September 22, 2015, at 10.

<sup>28</sup> Dafny, *supra* note 1, at 10.

<sup>29</sup> *Id.*

<sup>30</sup> Carol K. Kane, PhD., American Medical Association Policy Research Perspectives: Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership, July 2015.

<sup>31</sup> See Gregory J. Werden, *Monopsony and the Sherman Act: Consumer Welfare in a New Light*, 74 ANTITRUST L.J. 707 (2007) (explaining reasons to challenge monopsony power even where there is no immediate impact on consumers); Marius Schwartz, *Buyer Power Concerns and the Aetna-Prudential Merger*, Address before the 5th Annual Health Care Antitrust Forum at Northwestern University School of Law 4-6 (October 20, 1999) (noting that anticompetitive effects can occur even if the conduct does not adversely affect the ultimate consumers who purchase the end-product), available at: <http://www.usdoj.gov/atr/public/speeches/3924.wpd>.

rates paid to physicians is highly susceptible to the exercise of monopsony power through coordinated interaction by health insurance companies. The payment rates offered to large numbers of physicians by single health insurers are fairly uniform, and health insurance companies have a strong incentive to follow a price leader when it comes to payment rates.

Some have argued that physicians who are unhappy with the fees they receive from a powerful insurer could turn away from that insurer and instead treat more Medicare and Medicaid patients. However, physicians cannot increase their revenue from Medicare and Medicaid in response to a decrease in commercial health insurer payment. Enrollment in these programs is limited to special populations, and these populations only have a fixed number of patients. Physicians switching to Medicare and Medicaid plans would have to incur substantial marketing costs to pull existing Medicare and Medicaid patients from their existing physicians. Moreover, public programs underpay providers. Thus, even if a physician dropping a commercial health insurer could attract Medicare and Medicaid, this strategy would be a losing proposition, especially at a time when value-based payment models require practice investments.

## THE PROPOSED MEGAMERGER IS LIKELY TO HARM CONSUMERS

We have evaluated the potential effects of the proposed megamerger on both (1) the sale of health insurance products to employers and individuals (the sell side); and (2) the purchase of health care provider (including physician) services (the buy side).<sup>32</sup> We have concluded that on the sell side the merger is likely to result in higher premium levels to health care consumers and/or a reduction in the quality of health insurance that can take the form of a reduction in the availability of providers, a reduction in consumer service, etc. On the buy side, the merger could enable the merged entity to lower payment rates for physicians such that there would be a reduction in the quality or quantity of the services that physicians are able to offer patients.

### *Likely Detrimental Effects for Consumers in the Health Insurance Marketplace*

#### Price Increases

A growing body of peer-reviewed literature suggests that greater consolidation leads to price increases, as opposed to greater efficiency or lower health care costs.

Two studies have examined the effects of past health insurance mergers on premiums. A study of the 1999 merger between Aetna and Prudential found that the increased market concentration was associated with higher premiums.<sup>33</sup> Most recently, a second study examined the premium impact of the 2008 merger between UnitedHealth Group Inc. and Sierra Health Services. That merger led to a large increase in concentration in Nevada health insurance markets. The study concluded that in the wake of the merger, premiums in Nevada markets increased by almost 14%

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<sup>32</sup> See e.g. *U.S. v. Aetna Inc.*, supra note 12, at ¶¶ 17-18; *United States v. UnitedHealth Group Inc.* No. 1:05CV02436 (D.D.C., Dec. 20, 2005) (complaint), available at [www.usdoj.gov/atr/cases/f213800/213815.htm](http://www.usdoj.gov/atr/cases/f213800/213815.htm).

<sup>33</sup> Leemore Dafny et al, “Paying a Premium on your Premium? Consolidation in the US health insurance industry,” *American Economic Review* 2012; 102: 1161-1185.

relative to a control group. These findings suggest that the merging parties exploited their resulting market power, to the detriment of consumers.<sup>34</sup>

Also, recent studies suggest premiums for employer sponsored fully insured plans are rising more quickly in areas where insurance market concentration is increasing.<sup>35</sup>

Consistent with the observation that the loss of competition accompanying health insurer mergers results in higher premiums is research finding that competition among insurers is associated with lower premiums.<sup>36</sup> Research suggests that on the federal health insurance marketplaces, the participation of one new large carrier (i.e. UnitedHealth Group Inc.) would have reduced premiums by 5.4%, while the inclusion of all companies in the individual insurance markets could have lowered rates by 11.1%.<sup>37</sup> Professor Dafny observes that there are a number of studies documenting lower insurance premiums in areas with more insurers, including on the state health insurance marketplaces, the large group market, and in Medicare Advantage.<sup>38</sup>

### Plan Quality

The merger can be expected to adversely affect health insurance plan quality. Insurers are already creating very narrow and restricted networks that force patients to go out-of-network to access care. A merger would reduce pressures on plans to offer broader networks to compete for members and would create fewer networks that are simultaneously under no competitive pressure to respond to patients' access needs. As a result, it is even more likely that patients will find themselves in inadequate networks and be forced to access out-of-network care at some point. Similarly, it is very likely that patients will find themselves at in-network hospitals where, given their restricted network plans, many of the hospitals' physicians will not have been offered a contract by the insurer.

While the relationship between insurer consolidation and plan quality requires additional research, one study in the Medicare Advantage market found that more robust competition was associated with greater availability of prescription drug benefits.<sup>39</sup> As Professor Dafny observes, "the competitive mechanisms linking diminished competition to higher prices operate similarly with respect to lower quality."<sup>40</sup>

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<sup>34</sup> Jose R. Guardado, David W. Emmons, and Carol K. Kane, "The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra" *Health Management, Policy and Innovation*, 2013; 1(3) 16-35.

<sup>35</sup> Dafny, *supra* note 1, at 11.

<sup>36</sup> Dafny et al., *supra* note 1, at 11.

<sup>37</sup> Leemore Dafny, Jonathan Gruber and Christopher Ody. "More Insurers, Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces," *American Journal of Health Economics*, 2015: 1(1)53-81.

<sup>38</sup> Dafny *supra* note 1, at 11.

<sup>39</sup> Dafny *supra*, note 1 at 11.

<sup>40</sup> Robert Town and Su Liu, "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* (2003): 719-736.

*The Health Insurer Monopsony Power Acquired Through the Merger Would Likely Degrade the Quality and Reduce the Quantity of Physician Services*

Just as the proposed merger would enable the merged firm to raise premiums or reduce levels of service, it would also be likely to be able to lower payment rates for physicians to a degree that would reduce the quality or quantity of services that they offer to patients.

The DOJ has successfully challenged two health insurer mergers (half of all cases brought against health insurer mergers) based in part on DOJ claims that the mergers would have anticompetitive effects in the purchase of physician services. These challenges occurred in the merger of Aetna and Prudential in Texas in 1999,<sup>41</sup> and the merger of UnitedHealth Group Inc. and Pacific Care in Tucson, Arizona and in Boulder, Colorado in 2005.<sup>42</sup>

In a third merger matter occurring in 2010—Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan—the health insurers abandoned their merger plans when the DOJ complained that the merger “...would have given Blue Cross Michigan the ability to control physician payment rates in a manner that could harm the quality of healthcare delivered to consumers.”<sup>43</sup>

DOJ’s monopsony challenges properly reflect the Agency’s conclusions that it is a mistake to assume that a health insurer’s negotiating leverage acquired through merger is a good thing for consumers. On the contrary, consumers can expect higher insurance premiums.”<sup>44</sup> Health insurer monopsonists typically are also monopolists.<sup>45</sup> Facing little if any competition, they lack the incentive to pass along cost savings to consumers.

Consumers do best when there is a competitive market for purchasing physician services. This was the well-documented conclusion reached in the 2008 hearings before the Pennsylvania Insurance Department on the competition ramifications of the proposed merger between Highmark, Inc. and Independence Blue Cross. Based on an extensive record of nearly 50,000 pages of expert and other commentary,<sup>46</sup> the Pennsylvania Insurance Department was prepared to find the proposed merger to be anticompetitive in large part because it would have granted the merged health insurer undue leverage over physicians and other health care providers. This leverage would be “to the detriment of the insurance buying public” and would result in “weaker

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<sup>41</sup> *U.S. v. Aetna Inc.*, supra note 12, at ¶¶ 17-18; see also *U.S. v. Aetna, Inc.*, No. 3-99 CV 1398-H, at 5-6 (Aug. 3, 1999) (revised competitive impact statement), available at <http://www.usdoj.gov/atr/case/s/f2600/2648.pdf>.

<sup>42</sup> *United States v. UnitedHealth Group Inc.* No. 1:05CV02436 (D.D.C., Dec. 20, 2005) (complaint), available at: [www.usdoj.gov/atr/cases/f213800/213815.htm](http://www.usdoj.gov/atr/cases/f213800/213815.htm).

<sup>43</sup> Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans | OPA | Department of Justice, available at: <http://www.justice.gov/opa/pr/blue-cross-blue-shield-michigan-and-physicians-health-plan-mid-michigan-abandon-merger-plans>.

<sup>44</sup> Dafny, supra note 1, at 9.

<sup>45</sup> Peter J. Hammer and William M. Sage, *Monopsony as an Agency and Regulatory Problem in Health Care*, 71 ANTITRUST. L.J. 949 (2004).

<sup>46</sup> See [http://www.ins.state.pa.us/ins/lib/ins/whats\\_new/Excerpts\\_from\\_PA\\_Insurance\\_Dept\\_Expert\\_Reports.pdf](http://www.ins.state.pa.us/ins/lib/ins/whats_new/Excerpts_from_PA_Insurance_Dept_Expert_Reports.pdf) for background information, including excerpts from the experts.

provider networks for consumers who depend on these networks for access to quality healthcare.”<sup>47</sup> The Pennsylvania Insurance Department further concluded:

Our nationally renowned economic expert, LECG, rejected the idea that using market leverage to reduce provider reimbursements below competitive levels will translate into lower premiums, calling this an “economic fallacy” and noting that the clear weight of economic opinion is that consumers do best when there is a competitive market for purchasing provider services. LECG also found this theory to be borne out by the experience in central Pennsylvania, where competition between Highmark and Capital Blue Cross has been good for providers and good for consumers.<sup>48</sup>

For example, compensation below competitive levels hinders physicians’ ability to invest in new equipment, technology, training, staff and other practice infrastructure that could improve the access to, and quality of, patient care. Such investments are critical for enabling physicians to successfully transition into new value-based payment and delivery models. The merged insurer’s exercise of monopsony power may also force physicians to spend less time with patients to meet practice expenses. The mergers may also cause even tighter provider networks, reducing patient access to physicians and effectively curtailing the quantity of their services. Finally, when one or more health insurers dominate a market, physicians can be pressured not to engage in aggressive patient advocacy, a crucial safeguard of patient care.

Such reduction in service levels and quality of care causes immediate harm to consumers. In the long run, it is imperative to consider whether monopsony power will harm consumers by driving physicians from the market. Health insurer payments that are below competitive levels may reduce patient care and access by motivating physicians to retire early or seek opportunities outside of medicine that are more rewarding, financially or otherwise. According to a 2015 study released by the Association of American Medical Colleges, the U.S. will face a shortage of between 46,000-90,000 physicians by 2025. The study, which is the first comprehensive national analysis that takes into account both demographics and recent changes to care delivery and payment methods, projects shortages in both primary and specialty care.<sup>49</sup> Recent projections by the Health Resources and Services Administration similarly suggest a significant shortage of primary care physicians in the United States.<sup>50</sup>

Moreover, according to a recent survey by Deloitte, six in 10 physicians said it was likely that many physicians would retire earlier than planned in the next one to three years, a perception that Deloitte stated is fairly uniform among all physicians, irrespective of age, gender, or medical specialty.<sup>51</sup> According to the Deloitte survey, 57% of physicians also said that the practice of

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<sup>47</sup> See Statement of Pennsylvania Insurance Commissioner Joel Ario on Highmark and IBC Consolidation (January 22, 2009).

<sup>48</sup> Id.

<sup>49</sup> See IHS Inc., The Complexities of Physician Supply and Demand: Projections from 2013 to 2025. Prepared for the Association of American Medical Colleges. Washington, DC: Association of American Medical Colleges; 2015.

<sup>50</sup> See Health Resources and Services Administration, Projecting the Supply and Demand for Primary Care Physicians through 2020 in Brief (November 2013).

<sup>51</sup> Deloitte 2013 Survey of U.S. Physicians: Physician perspectives about health care reform in the future of the medical profession.

medicine was in jeopardy and nearly 75% of physicians thought that the “best and the brightest” may not consider a career in medicine. Finally, most physicians surveyed believed that physicians would retire or scale back practice hours, based on how the future of medicine is changing.<sup>52</sup>

#### Monopsony Anticompetitive Effects May be Especially Felt by Consumers and Physicians in The Market for Medicare Advantage

Because this merger would result in monopsony power within the Medicare Advantage market the effect would likely be felt most acutely by physicians who specialize in providing services to the elderly. With limited capacity to expand their business to traditional Medicare, these physicians may be especially harmed by the exceptionally high degree of concentration in the Medicare Advantage market where the lack of competition enables insurers to depress fees paid to physicians for services under Medicare Advantage.

#### *OIR Should Reject the Application to Merge to Protect Consumers*

Given that the proposed merger would result in countless highly concentrated commercial and Medicare Advantage markets where the merged entity either possessed substantial market shares or could exercise buyer power through coordinated interaction, it is critical for OIR to oppose the proposed merger so that consumers and physicians have adequate competitive alternatives. Unless the application is rejected, the merged entity would likely be able to raise premiums, reduce plan quality, and lower payment rates for physicians to a degree that would reduce the quality or quantity of services that physicians offer to patients.

#### **MERGER EFFICIENCY CLAIMS ARE UNSUPPORTED AND SPECULATIVE**

The NAIC Competitive Standard provides that a merger may be approved if “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 such economies exceed the public benefits which would arise from not lessening competition; or the acquisition will substantially increase the availability of insurance, and the public benefits of the increase exceed the public benefits which would arise from not lessening competition.” This is a daunting test and reflects skepticism about efficiency defenses in merger cases also found in federal antitrust law.<sup>53</sup> (“The Supreme Court has never expressly approved an efficiencies defense to a section 7 claim....We remain skeptical about the efficiencies defense in general and about its scope in particular.”)<sup>54</sup> Under the Horizontal Merger Guidelines, Aetna’s claimed efficiencies are not to be credited unless they are “merger specific”—likely to be accomplished with the proposed merger and unlikely to be achieved in the absence of the merger. Also, claimed efficiencies must be “verifiable” and “cognizable,” meaning parties asserting the existence of efficiencies bear the burden of substantiating them with evidence relating to their

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<sup>52</sup> Id.

<sup>53</sup> See *St. Alphonsus Medical Center and Federal Trade Commission v. St. Luke’s*, 778 F.3d 775 (9<sup>th</sup> Cir, 2015).

<sup>54</sup> Id.

likelihood and magnitude and how each efficiency would enhance the merged firm's ability and incentive to compete. Finally, benefits must be passed through to customers:

The greater the potential adverse competitive effect of a merger, the greater must be the cognizable efficiencies, and the more they must be passed through to customers...When the potential adverse competitive effects of a merger is likely to be particularly substantial, extraordinarily great cognizable efficiencies would be necessary to prevent the merger from being anticompetitive.<sup>55</sup>

At the OIR hearing, Aetna met neither the NAIC Competitive Standard nor the Horizontal Merger Guidelines test for proving redeeming efficiencies. Aetna did not even identify, much less carry its burden of establishing, substantial economies of scale or economies in resource utilization. Aetna merely declares that it will achieve \$1.25 billion in operating cost savings by 2018 and that it will achieve "more affordable care." However, management's testimony was notable for its lack of clarity on how any savings from the merger would be achieved. And as Professor Dafny noted in her Senate testimony, there is still the question of whether benefits will be passed through to consumers in light of that diminished competition."<sup>56</sup> Indeed Aetna's claim of more affordable care is undermined by the studies of consummated health insurance mergers discussed above, which show that the mergers actually resulted in harm to consumers in the form of higher, not lower, insurance premiums.

The most notable scale related testimony was from Aetna management who mentioned the challenges they would face operating a firm with the large size of the merged entity. Failing to identify any economy of scale, Aetna of course did not address how any such economy could not be feasibly achieved in any other way. In sum, Aetna made no effort at the hearing to show that the claimed savings is (1) verifiable; (2) merger specific; and (3) greater than the transaction's substantial anticompetitive effects.

Aetna claims in a slide presentation that the merger would yield broad and vaguely defined "value-based care arrangements," "broader choice of products, and better overall health care experience." Management also repeatedly testified that the merger is "complementary" in the sense that Humana has the larger Medicare Advantage business and Aetna the larger commercial footprint and "focus" in that market.

Aetna's claim of "value-based care arrangements" emerging from the merger was unsupported. Also absent was evidence as to why value-based arrangements if achieved through the merger, would be unlikely to be achieved in the absence of a merger. Perhaps explaining the lack of evidence is Professor Leemore Dafny's Senate hearing on this merger: "there is no evidence that larger insurers are more likely to implement innovative payment and care management programs...[and] there is a countervailing force offsetting this heightened incentive to invest in...reform: more dominant insurers in a given insurance market are less concerned with ceding market share."<sup>57</sup> In fact, "concerted delivery system reform efforts have tended to emerge from

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<sup>55</sup> Horizontal Merger Guidelines, Section 10

<sup>56</sup> Id. at 16.

<sup>57</sup> Dafny, *supra* note 1, at 16.

other sources, such as provider systems...and non-national payers,” according to Professor Dafny, not commercial health insurers.<sup>58</sup>

As for a claimed broader choice of products, consumers would have the broadest choice of products if both Aetna and Humana competed. No explanation was offered at the hearing as to why a merger was necessary to expand product offerings.

Also, Aetna made no effort to explain why Humana’s having the larger Medicare Advantage business would help Aetna achieve an operating efficiency that could not be achieved without a merger. While a merger may be a quicker way for Aetna to gain market share in Medicare Advantage that now represents a smaller share of its business than commercial, to permit all such firms to satisfy their aspirations by horizontal merger could eviscerate competition.

Finally, the vague and unsubstantiated claim of a “better overall health experience” that Aetna would attribute to the merger cannot trump, under NAIC or federal merger standards, the adverse competitive effects that we have described earlier.

## CONCLUSION

Any remedy short of rejecting the merger application would not adequately protect consumers. A divestiture would not protect against the loss of potential competition that occurs when one of the largest health insurers is eliminated. Moreover, divestiture could be highly disruptive to the marketplace and cause harm to consumers, especially in Medicare Advantage markets where the elderly would be faced with a new insurer.

As a practical matter, the overwhelming number of markets adversely affected by the proposed merger, along with the barriers to entry to health insurance, makes unlikely that the OIR could find proposed buyers of assets that could supply health insurance at a cost and quality comparable to that of the merger parties in the huge number of affected markets. Moreover, any qualified purchaser able to contract with a cost competitive network of hospitals and physicians, if found, would likely already be a market participant, and a divestiture to such an existing market participant would not likely return the market to even pre-merger levels of competition.

Accordingly, AMA, FMA and FOMA respectfully urge the OIR to reject the parties’ application to merge in order to protect consumers from premium increases, lower plan quality and a reduction in the quantity and quality of physician services.

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<sup>58</sup> Id.



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November 11, 2015

The Honorable William Baer  
Assistant Attorney General  
United States Department of Justice  
Antitrust Division  
950 Pennsylvania Avenue, NW  
Washington, DC 20530

Dear Assistant Attorney General Baer:

The American Medical Association (AMA) greatly appreciates the opportunity to provide our comments to the Antitrust Division as it engages in the vital work of investigating Aetna's proposed acquisition of Humana and Anthem's proposed acquisition of Cigna. We believe that high insurance market concentration is an important issue of public policy because the anticompetitive effects of insurers' exercise of market power pose a substantial risk of harm to consumers. Our analyses of the proposed health insurance mergers reveal significant concerns with respect to the impact on consumers in terms of health care access, quality, and affordability.

#### SUMMARY

- The proposed mergers are occurring in markets where there has already been a near total collapse of competition. Under the U.S. Department of Justice/Federal Trade Commission Merger Guidelines, the proposed mergers are presumed to enhance market power in a vast number of commercial and Medicare Advantage markets. Because of persisting high barriers to entry in health insurance markets, the lost competition through these proposed mergers would likely be permanent and the acquired health insurer market power would be durable.
- A growing body of peer-reviewed literature suggests that greater health insurer consolidation leads to price increases, as opposed to greater efficiency or lower health care costs. The proposed mergers can be expected to lead to a reduction in health plan quality. Insurers are already creating very narrow and restricted networks that force patients to go out of network to access care. The mergers would reduce pressures on plans to offer broader networks to compete for members and would create fewer networks that are simultaneously under no competitive pressure to respond to patients' access needs.

- Health insurer monopsony, or buyer power, acquired through the proposed mergers would, as the Department of Justice has found in earlier cases, likely degrade the quality and reduce the quantity of physician services. Consumers do best when there is a competitive market for purchasing physician services. When mergers result in monopsony power and physicians are reimbursed at below competitive levels, consumers may be harmed in a variety of ways. Physicians may be forced to spend less time with patients to meet practice expenses. They also may be hindered in their ability to invest in new equipment, technology, training, staff, and other practice infrastructure that could improve the access to and quality of patient care and could enable physicians to successfully transition into new value-based payment and delivery models. Furthermore, in the long run health insurer exercise of monopsony power may motivate physicians to retire early or seek opportunities outside of medicine that are more rewarding. This would exacerbate an already significant shortage of primary care physicians in the United States.
- There is no evidence supporting the insurer's claim that the proposed mergers would lead to greater efficiencies and innovative payment and care management programs. There is also no economic evidence that consumers benefit when health insurers merge to respond to hospital consolidation by acquiring countervailing power.
- Fostering competition, not consolidation, benefits American consumers through lower prices, better quality, and greater choice.
- Accordingly, the AMA urges the Department of Justice to block the proposed mergers.

#### THE FOUNDATION FOR AMA'S CONCLUSIONS

The AMA has participated in Congressional hearings on Anthem's proposed acquisition of Cigna and Aetna's proposed acquisition of Humana. In the course of these hearings, the AMA has analyzed the likely competitive effects of these mergers both in the sell-side market for insurance and the buy-side market for physician services. The AMA has considered data compiled annually by the AMA on competition in health insurance, recent studies on the effects of health insurance mergers, the testimony of experts called by House and Senate committees, and the written submissions and testimony of the merging parties.

The AMA has reviewed this matter from the long-standing AMA perspective that competition in health insurance, not consolidation, is the right prescription for health insurer markets. Competition will lower premiums, force insurers to enhance customer service, pay bills accurately and on time, and develop and implement innovative ways to improve quality while lowering costs. Competition also allows physicians to bargain for contract terms that touch all aspects of patient care.

The AMA has concluded that these mergers are likely to impair access, affordability, and innovation in the sell-side market for health insurance, and on the buy side, will deprive physicians of the ability to negotiate competitive health insurer contract terms in markets around the country. The result will be detrimental to consumers. "If past is prologue," notes Leemore Dafny, Ph.D., "insurance consolidation will tend to lead to lower payments to healthcare providers, but those lower payments will not be passed

on to consumers. On the contrary, consumers can expect higher insurance premiums.”<sup>1</sup> Moreover, monopsony power acquired through the mergers would enable the health insurers to control physician payment rates in a manner that could harm the quality of healthcare delivered to consumers.<sup>2</sup> Therefore, the AMA opposes the proposed mergers.

## MARKET SHARES AND MARKET CONCENTRATION

Competition is likely to be greatest when there are many sellers, none of which has any significant market share. Unfortunately, health insurance markets are mostly highly concentrated, meaning that typically there are few sellers and they possess significant market shares. The AMA has determined that the proposed mergers are likely to create, enhance, or entrench market power in numerous markets.

### Commercial Health Insurance

For the past 14 years, the AMA has conducted the most in-depth annual study of commercial health insurance markets in the country. From 2001 to 2010, the study was based on the 1997 U.S. Department of Justice (DOJ) and Federal Trade Commission (FTC) Horizontal Merger Guidelines. Beginning with the 2011 Update, the AMA’s study utilizes the 2010 iteration of the Merger Guidelines to classify markets based on whether mergers announced in those markets would raise anticompetitive concerns.<sup>3</sup> The AMA’s most recently published study, *Competition in Health Insurance: A Comprehensive Study of US Markets* (2015 update) is intended to help researchers, policymakers, and federal and state regulators identify areas of the country where consolidation among health insurers may have harmful effects on consumers, on providers of care, and on the economy. It presents health insurance market shares and concentration levels in states and metropolitan statistical areas (MSA). The AMA’s study shows that there has been a near total collapse of competition in commercial, combined HMO + PPO + POS markets. In seven out of 10 metropolitan areas, these markets are highly concentrated. Moreover, 38 percent of metropolitan areas had a single health insurer with a commercial market share of 50 percent or more. Fourteen states have a single health insurer with at least a 50 percent share of the commercial health insurance market.

### Medicare Advantage

The 2015 Update to its Competition in Health Insurance study does not cover the Medicare Advantage markets, which is where the merger of Humana and Aetna will be most acutely felt. However, competitive conditions in Medicare Advantage markets appear to be even more troubling than in the commercial health insurance market studied by the AMA. According to a Commonwealth Fund study published last month, 97 percent of Medicare Advantage markets (evaluated geographically at the county level) are highly concentrated and therefore characterized by a lack of competition.<sup>4</sup>

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<sup>1</sup> See Dafny, “Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?” Testimony before the Senate Committee on the Judiciary, September 22, 2015, at 10.

<sup>2</sup> Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans | OPA | Department of Justice, available at: <http://www.justice.gov/opa/pr/blue-cross-blue-shield-michigan-and-physicians-health-plan-mid-michigan-abandon-merger-plans>

<sup>3</sup> U.S. Dep’t of Justice and Fed. Trade Comm’n, Horizontal Merger Guidelines (Aug. 19, 2010), available at: <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>.

<sup>4</sup> B. Biles, G. Casillas, and S. Guterman, *Competition Among Medicare’s Private Health Plans: Does It Really Exist?* The Commonwealth Fund, August 2015.

Aetna has argued that insurer share of Medicare Advantage is of no antitrust relevance given that consumers have the option of enrolling in traditional Medicare and therefore, in Aetna's view, traditional Medicare and Medicare Advantage plans are not separate product markets.<sup>5</sup> This argument glosses over the many critically important differences between Medicare Advantage and traditional Medicare that explain why Medicare is not an adequate substitute for Medicare Advantage, such that the proposed mergers should be evaluated for their effects in the Medicare Advantage market separately. Medicare Advantage plans offer substantially richer benefits at lower costs than traditional Medicare.<sup>6</sup> Moreover, in Medicare Advantage plans seniors can receive a single plan covering a variety of benefits that seniors in traditional Medicare must assemble themselves. The combination of richer benefits and one stop shopping accounts for the strong preference by many seniors for Medicare Advantage plans. Accordingly, seniors are not likely to switch away from Medicare Advantage plans to traditional Medicare in sufficient numbers to make an anticompetitive price increase or reduction in quality unprofitable to a Medicare Advantage insurer.<sup>7</sup> The closest competition to one Medicare Advantage insurer's plan is another insurer's Medicare Advantage plan and the presence of many competing Medicare Advantage insurers is what keeps quality competitive. Consequently, the Medicare Advantage and traditional Medicare programs constitute separate and distinct product markets and the proposed mergers should be evaluated for their effects in a Medicare Advantage market.<sup>8</sup>

## THE HEALTH INSURER MERGERS CREATE, ENHANCE, OR ENTRENCH MARKET POWER IN THE SALE OF HEALTH INSURANCE

### *The Anthem-Cigna Merger*

Utilizing data obtained from HealthLeaders-Interstudy Managed Market Surveyor from January 1, 2013, the AMA has determined the commercial health insurance market concentrations and change in market concentrations that would result from the Anthem-Cigna merger. The AMA analysis shows the proposed Anthem-Cigna merger would be presumed likely, under the Merger Guidelines, to enhance market power in 85 commercial (combined HMO + PPO + POS) MSA markets. The AMA also considered the effect of the merger using states as a geographic market. The AMA found that within 10 of the 14 states (NH, IN, CT, ME, VA, GA, CO, MO, NV, and KY) in which Anthem is licensed to provide commercial coverage, the merger is likely to enhance market power. In the remaining four states (OH, CA, NY, and WI), the merger would potentially raise significant competitive concerns and warrant scrutiny under the Merger Guidelines.

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<sup>5</sup> Bertolini, "Examining Consolidation in the Health Insurance Industry and its Impact on Consumers," Testimony before the Senate Committee on the Judiciary, September 22, 2015, at 5.

<sup>6</sup> See *U.S. v. United Health Group and Sierra Health Services Inc.*, Civil No 1:08 -cu-00322 (DDC2008); *United States v. Humana*, No. 12-cv-00464 (D.D.C. Mar. 27, 2012), available at: [www.justice.gov/atr/cases/f281600/281618.pdf](http://www.justice.gov/atr/cases/f281600/281618.pdf).

<sup>7</sup> See competitive impact statement, *United States v. United health*, *supra*, at 4-5.

<sup>8</sup> See *U.S. v. United Health Group and Sierra Health Services Inc.*, Civil No 1:08 -cu-00322 (DDC2008) (the DOJ alleged that MA is a distinct market separate from the Medicare market and obtained a consent decree requiring the divestiture of United's MA business in the Las Vegas area as a precondition to obtaining merger approval); see also Gretchen A. Jacobson, Patricia Neuman, Anthony Damico, "At Least Half Of New Medicare Advantage Enrollees Had Switched From Traditional Medicare During 2006–11," 34 *Health Affairs* (Millwood) 48, 51 (Jan. 2015), available at:

<http://content.healthaffairs.org/content/34/1/48.full.pdf>; R. Town and S. Liu (2003), "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* 34(4): 719-36; L.Dafny and D. Dranove (2008), "Do Report Cards Tell Consumers Anything They Don't Already Know?" *RAND Journal of Economics* 39.

Confirming the grave structural harm found by the AMA in numerous commercial health insurance markets is a slightly different market study commissioned by the American Hospital Association (AHA). That study examined MSAs *and rural counties* as the relevant geographic markets. The AHA reports that the transaction threatens to reduce competition in the sale of commercial health insurance in at least 817 relevant geographic markets. In 600 of these markets the transaction would be presumed to be likely to enhance market power under the Merger Guidelines. In another 217 markets the AHA found that under the Merger Guidelines the merger would potentially raise significant competitive concerns.

The health insurers have asked regulators to assume, without evidence, that health insurance markets are competitive “due to numerous competitors” and “other market realities.” For example, in Anthem’s Competitive Impact Analysis that was part of its September 22, 2015, Connecticut Insurance Department application, the insurer contends:

Due to the numerous competitors, changing health care dynamics, new entrants, public and private exchanges, new distribution channels and business models, increasing transparency, sophisticated purchasers, and other marketplace realities, Anthem believes that Anthem’s acquisition of control of CIGNA will not substantially lessen competition in insurance or tend to create a monopoly in the State of Connecticut with respect to any line of business.

Notably, the Anthem “competitive analysis” provides no evidence in support of its contention that the health insurance industry in Connecticut is highly competitive and becoming more competitive. Anthem provides no data to support this opinion—no reporting of market shares, Herfindahl-Hirschman Indices (HHI), or changes in either as a result of the proposed merger. Anthem’s only mention of market shares is the motivation for why it prepared the analysis in the first place: In the commercial health insurance lines of business (as well as vision and dental standalone lines of business), the Anthem-Cigna merger does not meet the pre-acquisition notification exemption standard set forth in the Connecticut General Statutes. Instead, Anthem simply lists competitors to Anthem and Cigna in the individual, small group, large group, standalone vision and standalone dental lines of business as its primary evidence of competition, and argues that the growing use of public and private exchanges, benefit administration platforms, and other technology improvements will further ensure that “competition within the health insurance market will remain vigorous and vibrant.”

In contrast, a review of data from the AMA’s 2015 Update to its Competition in Health Insurance study, the Connecticut Insurance Department, and the Government Accountability Office’s December 2014 report on private health insurance concentration, show that Connecticut’s health insurance market is already highly concentrated. Using data from its 2015 Update, a special analysis conducted by the AMA in September 2015 shows that the proposed merger between Anthem and Cigna would exceed federal antitrust guidelines in Connecticut (i.e., increase in HHI of 1,311 points for a post-merger total HHI of 3,855) and in six of its metropolitan areas (MSAs).

### ***The Aetna-Humana Merger***

Turning to the proposed merger of Humana and Aetna, that merger would combine one of the two largest insurers of Medicare Advantage (Humana) with the fourth largest (Aetna) to form the largest Medicare

Advantage insurer in the country.<sup>9</sup> This would further concentrate a market that is already “highly concentrated among a small number of firms.”<sup>10</sup> As in the case of the Anthem/Cigna merger, the Aetna/Humana merger would have a substantial impact on a staggering number of markets. According to a market study commissioned by the AHA, more than 1000 markets (defined geographically as counties) would become highly concentrated. Under the Merger Guidelines, the merger is presumed to be likely to enhance market power in 924 counties and potentially raises significant competitive concerns in another 159 counties.

In addition to presumptively enhancing market power in Medicare Advantage markets, the Aetna/Humana merger will exacerbate the near total collapse of competition in commercial markets. AMA analysis shows that the merger would be presumed to enhance market power in the commercial markets of health insurance in 15 MSAs within seven states (FL, GA, IL, KY, OH, TX, and UT).

#### ***Competition for Contracts in National Market***

There may also be a national market in which the health insurers compete or potentially compete for the contracts of large national employers. In that market there are only five national health insurance companies remaining today: Anthem, Cigna, Aetna, Humana and United Healthcare. The proposed Anthem/Cigna and Aetna/Humana mergers would pare the number of national players to three.

#### **THE HEALTH INSURER MERGERS CREATE, ENHANCE, OR ENTRENCH MONOPSONY POWER IN MARKETS FOR THE PURCHASE OF PHYSICIAN SERVICES**

Just as the health insurer mergers would enhance market power on the selling side of the market, the mergers also would enhance monopsony or buyer’s power in the purchase of inputs such as physician services, eviscerating physicians’ ability to contract with alternative insurers in the face of unfavorable contract terms and ultimately inefficiently reducing the quality or quantity of services that physicians are able to offer patients. As Professor Dafny explained in her Senate testimony on these mergers, “Monopsony is the mirror image of monopoly; lower input prices are achieved by reducing the quantity or quality of services below the level that is socially optimal.”<sup>11</sup> When as here firms can also exercise seller power, the reduced prices for inputs (physician services) cause higher, not lower, output prices (health insurance premiums). See *Telecor Communications, Inc. v. S.W. Bell Tel. Co.*, 305 F.3d 1124, 1136 (10th Cir. 2002) (explaining that monopsony affects consumers because “there is a dead-weight loss associated with imposition of monopsony pricing restraints,” and “[s]ome producers will either produce less or cease production altogether, resulting in less-than-optimal output of the product or service, and over the long run higher consumer prices, reduced product quality, or substitution of less efficient alternative products”). In addition to producing higher insurance premiums and a reduction in the quantity and quality of physician services, the lower than competitive physician reimbursements will deny physicians the rates necessary to support delivery reforms associated with value-based care, the cost of which the physicians—not the health insurers—must bear.

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<sup>9</sup> Gretchen Jacobson, Anthony Damico, and Marsha Gold, Kaiser Family Foundation Issue Brief, *Medicare Advantage 2015 Spotlight: Enrollment Market Update*, (June 30, 2015), Figure 1, available at: <http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/>.

<sup>10</sup> Id. at 13.

<sup>11</sup> Dafny at 10

In concluding that the mergers would enhance monopsony power, the AMA has followed the analytical techniques supplied by the Merger Guidelines, which require a definition of both a product market and geographic market.

The relevant product market is physician services. Insurers purchase many inputs, including physician services. There are no adequate substitutes for physician services, due to training and expertise.<sup>12</sup> Moreover, physicians are confined to supplying services within their training and licensure and cannot do something else in response to a decrease in compensation.<sup>13</sup>

The geographic markets in which health insurers secure services from physicians roughly coincide with the localized geographic markets in which the insurer sells its services to consumers.<sup>14</sup> Health insurers must obtain physician coverage in each locale where they sell insurance. Physicians are not mobile—they invest and develop their practices locally. Accordingly, the DOJ has embraced the notion of a localized market in which health insurers purchase physician services.<sup>15</sup> As the DOJ explained in the Aetna/Prudential complaint:

The patient preferences that define a localized geographic market for the sale of HMO and HMO-POS products also define a localized geographic market for physician services. Moreover, for an established physician who has invested time and expense in building a practice, the costs associated with moving his or her practice to a new geographic market are considerable, including paying for new office space and equipment and building new relationships with hospitals, other physicians, employees, and patients in the area.<sup>16</sup>

A loss of competition on the buy side can occur within the localized geographic markets when the merging health insurers hold contracts with a significant number of providers who are financially dependent on contracting with the merging health plans and could not readily replace that business by dealing with other payers.<sup>17</sup>

According to Professor Dafny, the “textbook monopsony scenario...pertains when there is a large buyer and fragmented suppliers.”<sup>18</sup> This characterizes the market in which dominant health insurers purchase the services of physicians who typically work in small practices with 10 or fewer physicians.<sup>19</sup> Moreover, if physicians were to refuse the terms of any health insurer, they would likely suffer an irretrievable loss of revenue. That is because medical services can neither be stored nor exported. Consequently, a physician’s ability to consider realistically terminating a relationship with the merged insurers because of

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<sup>12</sup> See *U.S. v. United Health Group and Sierra Health Services Inc.*, Civil No1: 08 -cu-00322 (DDC2008), affidavit of Professor David Dranove, PhD (February 25, 2008).

<sup>13</sup> Id.

<sup>14</sup> See e.g., Capps, C. Buyer Power in Health Plan Mergers, *J Comp Law and Econ.* 2009; 6:375-391

<sup>15</sup> See e.g. *U.S. v. Aetna Inc.*, Complaint, No. 3-99CV 1398-H, ¶ 20 (June 21, 1999), available at <http://www.justice.gov/file/483516/download>, (alleging that the relevant geographic markets were the MSAs in and around Houston and Dallas, Texas).

<sup>16</sup> Id. at ¶¶ 19-20.

<sup>17</sup> Christine White, Sarahlisa Brau, and David Marx, *Antitrust and Healthcare: A Comprehensive Guide*, at 163 (2013); see also U.S. Dep’t of Justice and Fed. Trade Comm’n, *Horizontal Merger Guidelines*, supra 1, at page 33; Federal Trade Commission and U.S. Department of Justice, *Improving Health Care: A Dose of Competition* (July, 2004), at 15.

<sup>18</sup> See Dafny, “Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?,” Testimony before the Senate Committee on the Judiciary, September 22, 2015, at 10.

<sup>19</sup> Carol K. Kane, PhD, *American Medical Association Policy Research Perspectives: Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership*, July 2015.

low payment rates depends on that physician's ability to make up lost business by immediately switching to an alternative health insurer. However, it is difficult to convince consumers (which in many cases are employers) to switch to different health insurers.<sup>20</sup> Also, switching health insurers is a very difficult decision for physicians because it impacts their patients and disrupts their practice. The physician-patient relationship is a very important aspect to the delivery of high-quality healthcare. And it is a very serious decision both personally and professionally for physicians to disrupt this relationship by dropping a health insurer.

Given the nature of physician practices, even in markets where the merged health insurers lack monopoly or market power to raise premiums for patients, the insurers still may have the power to force down physician compensation levels, raising antitrust concerns. Thus, in the *UnitedHealth Group Inc./Pacificare* merger, the DOJ required a divestiture based on monopsony concerns in Boulder, Colorado, even though the merged entity would not necessarily have had market power in the sale of health insurance. The reason is straightforward: the reduction in compensation would lead to diminished service and quality of care, which harms consumers even though the direct prices paid by subscribers do not increase.<sup>21</sup>

Moreover, the reductions in the number of health insurers can create health insurer oligopolies that, through coordinated interaction, can exercise buyer power. Indeed the setting of payment rates paid to physicians is highly susceptible to the exercise of monopsony power through coordinated interaction by health insurance companies. The payment rates offered to large numbers of physicians by single health insurers are fairly uniform, and health insurance companies have a strong incentive to follow a price leader when it comes to payment rates.

Some have argued that physicians who are unhappy with the fees they receive from a powerful insurer could turn away from that insurer and instead treat more Medicare and Medicaid patients. However, physicians cannot increase their revenue from Medicare and Medicaid in response to a decrease in commercial health insurer payment. Enrollment in these programs is limited to special populations, and these populations only have a fixed number of patients. Physicians switching to Medicare and Medicaid plans would have to incur substantial marketing costs to pull existing Medicare and Medicaid patients from their existing physicians. Moreover, public programs underpay providers. Thus, even if a physician dropping a commercial health insurer could attract Medicare and Medicaid, this strategy would be a losing proposition, especially at a time when value-based payment models require practice investments. Consequently, health insurers can exercise monopsony power in the commercial health insurance market.<sup>22</sup>

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<sup>20</sup> See e.g. *U.S. v. UnitedHealth Group and Pacificare Health Systems*, Complaint, No. 1:05CV02436, ¶ 37 (December 20, 2005), available at <http://www.justice.gov/file/514011/download>. (As alleged in the United/PacifiCare complaint, physicians encouraging patients to change plans “is particularly difficult for patients employed by companies that sponsor only one plan because the patient would need to persuade the employer to sponsor an additional plan with the desired physician in the plan’s network” or the patient would have to use the physician on an out-of-network basis at a higher cost)..

<sup>21</sup> See Gregory J. Werden, *Monopsony and the Sherman Act: Consumer Welfare in a New Light*, 74 ANTITRUST L.J. 707 (2007) (explaining reasons to challenge monopsony power even where there is no immediate impact on consumers); Marius Schwartz, *Buyer Power Concerns and the Aetna-Prudential Merger*, Address before the 5th Annual Health Care Antitrust Forum at Northwestern University School of Law 4-6 (October 20, 1999) (noting that anticompetitive effects can occur even if the conduct does not adversely affect the ultimate consumers who purchase the end-product), available at: <http://www.usdoj.gov/atr/public/speeches/3924.wpd>.

<sup>22</sup> Peter J. Hammer and William M. Sage, “Monopsony as an Agency and Regulatory Problem in Health Care,” 71 Antitrust L.J. 949 (2004)

Given the high market concentration levels and large commercial and MA market shares that would result from the proposed mergers in the numerous MSAs and counties identified by the AMA and AHA, the proposed Mergers would create, enhance, or entrench monopsony power.

## BARRIERS TO ENTRY AND THE NEED TO PRESERVE POTENTIAL COMPETITION

The market share and concentration data do not overstate the mergers' future competitive significance in health insurance and physician markets. This is not a case where new market entry could defeat an exercise of monopoly or monopsony power. Instead, lost competition through a merger of health insurers is likely to be permanent and acquired health insurer market power would be durable because barriers to entry prevent the higher profits often associated with concentrated markets from allowing new entrants to restore competitive pricing. These barriers include state regulatory requirements; the need for sufficient business to permit the spreading of risk; and contending with established insurance companies that have built long-term relationships with employers and other consumers.<sup>23</sup> In addition, a DOJ study of entry and expansion in the health insurance industry found that "brokers typically are reluctant to sell new health insurance plans, even if those plans have substantially reduced premiums, unless the plan has strong brand recognition or a good reputation in the geographic area where the broker operates."<sup>24</sup>

Perhaps the greatest obstacle is the so-called chicken and egg problem of health insurer market entry: health insurer entrants need to attract customers with competitive premiums that can only be achieved by obtaining discounts from providers. However providers usually offer the best discounts to incumbent insurers with a significant business—volume discounting that reflects a reduction in transaction costs and greater budget certainty. Hence, incumbent insurers have a durable cost advantage.<sup>25</sup>

The presence of significant entry barriers in health insurance markets was demonstrated in the 2008 hearings before the Pennsylvania Insurance Department on the competition ramifications of the proposed merger between Highmark Inc. and Independence Blue Cross. Substantial evidence was introduced in those hearings, showing that replicating the Blues' extensive provider networks constituted a major barrier to entry. The evidence further demonstrated that there has been very little in the way of new entry that might compete with the dominant Blues Plans in the Pennsylvania health insurance markets. In a report commissioned by the Pennsylvania Insurance Department, LECG concluded that it was unlikely that any competitor would be able to step into the market after a Highmark/IBC merger:

[B]ased on our interviews of market participants and other evidence, there are a number of barriers to entry—including the provider cost advantage enjoyed by the dominant firms in those areas and the strength of the Blue brand in those areas...On balance, the evidence suggests that to the extent the proposed consolidation reduces competition, it is

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<sup>23</sup> See Robert W. McCann, *Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field."* Health Law Handbook (Thomson West 2007); Mark V. Pauly, *Competition in Health Insurance Markets*, 51 Law & Contemp. Probs. 237 (1988); Federal Trade Commission and U.S. Department of Justice, *Improving Health Care: A Dose of Competition* (July, 2004); *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 Law & Contemp. Probs. 195 (1988).

<sup>24</sup> Sharis A. Pozen, Acting Assistant Att'y Gen., Dep't of Justice Antitrust Div., *Competition and Health Care: A Prescription for High-Quality, Affordable Care* 7 (Mar. 19, 2012) [hereinafter Pozen, *Competition and Health Care*], available at <http://www.justice.gov/atr/speech/competition-and-health-care-prescription-high-quality-affordable-care>.

<sup>25</sup> Id. at 7.

unlikely that other health insurance firms will be able to step in and replace the loss in competition.<sup>26</sup>

The merging health insurers have argued that times have changed and the health insurance marketplaces have made entry easy. The facts however do not bear out that claim. Recent state developments only highlight the barrier to entry problem. The *New York Times* recently reported “tough going for health co-ops” created under the Affordable Care Act (ACA) to inject competition into health insurance markets.<sup>27</sup> According to the *Times*, many co-ops “appear to be scrambling to have enough money to cover claims as well as enroll new customers as they enter their third year.” According to the *Washington Post* of October 10, nearly half of the 23 ACA insurance co-ops, subsidized by millions of dollars in government loans, have been told by federal regulators that their finances, enrollment, or business model need to “shape up.” One co-op has folded and four others are preparing to close in late December, including top-tier co-ops that federal officials had regarded as best poised to succeed.<sup>28</sup> More closure announcements are expected.<sup>29</sup> The quick death of these co-ops illustrate that even with heavy federal subsidies, health insurance is a tough business to enter.

Moreover, only two for-profit companies that were not already health insurers, reports the *Times*, have entered the state marketplaces. One of them is Oscar, which was touted by the CEOs of Aetna and Anthem as an example of successful entry in their testimony before the Senate Judiciary Committee. (Anthem’s CEO referred to Oscar as “emblematic of the changing face of the competitive landscape in the insurance industry.”) However, according to the *Times*, Oscar estimated in a regulatory filing that it lost about \$27.5 million last year, roughly half of its 2014 revenue. The CEO of Oscar, one of the very few new companies to even attempt entry, described the task as “quite daunting.”<sup>30</sup> In any event, the insurers’ bold claim of new entry is not evidence and their descriptions of new entry opportunities are as consistent with the insurance markets experiencing net exit as with their assertions of net entry.

### ***The Loss of Potential Competition***

One of the most important implications of the barriers to entry that persist with the advent of the exchanges is the need to preserve the potential competition that would be lost if an incumbent insurer is acquired. Thus, when one of the two largest insurers of Medicare Advantage (Humana) is acquired by the fourth-largest (Aetna) to form the largest Medicare Advantage insurer in the country, the highly concentrated geographic markets where Humana faces little competition are deprived of their most likely entrant, Aetna. The foreclosure of this future market role serves to lessen competition. Professor Dafny expressed concern about this loss of potential competition in her Senate testimony: “[C]onsolidation even in non-overlapping markets reduces the number of potential entrants who might attempt to overcome price-increasing (or quality-reducing) consolidation in markets where they do not currently operate.”<sup>31</sup>

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<sup>26</sup> LECG Inc., “Economic Analyses of the Competitive Impacts From The Proposed Consolidation of Highmark and IBC.” September 10 2008, Page 9.

<sup>27</sup> “Tough going for Co-ops,” the *New York Times*, September 15, 2015, available at <http://www.nytimes.com/2015/09/16/business/health-cooperatives-find-the-going-tough.html?ref=health>

<sup>28</sup> “Financial health shaky at many Obamacare insurance co-ops,” The *Washington Post*, October 10, 2015, available at [https://www.washingtonpost.com/national/health-science/financial-health-shaky-at-many-obamacare-insurance-co-ops/2015/10/08/2ab8f3ec-6c66-11e5-9bfe-e59f5e244f92\\_story.html?postshare=3211444658813888](https://www.washingtonpost.com/national/health-science/financial-health-shaky-at-many-obamacare-insurance-co-ops/2015/10/08/2ab8f3ec-6c66-11e5-9bfe-e59f5e244f92_story.html?postshare=3211444658813888)

<sup>29</sup> *Id.*

<sup>30</sup> This \$1.5 billion Startup is Making Health Insurance Suck Less, *Wired*, March, 20, 2015, available at <http://www.wired.com/2015/04/oscar-funding/>.

<sup>31</sup> Dafny, *supra* note 15, at 13.

Commenting on the loss of potential competition that would accompany the proposed mergers, Professor Thomas L. Greaney, who is one of the country's leading experts on antitrust in healthcare, observes:

An important issue...is whether the proposed mergers will lessen *potential competition* that was expected under the ACA (the potential entry by large insurers into each other's markets, incidentally, was the argument advanced as to why a "public option" plan was unnecessary). At present all four of the merging companies compete on the exchanges and they overlap in a number of states. [citation omitted]. Notably, prior to the announced mergers, these insurers appear to have been considering further expanding their footprint on the exchanges by entering a number of new states. [citation omitted]. Thus reducing the array of formidable potential entrants into exchange markets from the "Big 5" to be "Remaining 3" will undermine the cost containment effects of competition in exchange markets. The lessons of oligopoly are pertinent here: consolidation that would pare the insurance sector down to less than a handful of players is likely to chill the enthusiasm for venturing into a neighbor's market or engaging in risky innovation. One need look no further than the airline industry for a cautionary tale.<sup>32</sup>

## THE PROPOSED MEGAMERGERS ARE LIKELY TO HARM CONSUMERS

The AMA has evaluated the potential effects of the proposed megamergers on both: (1) the sale of health insurance products to employers and individuals (the sell side); and (2) the purchase of health care provider (including physician) services (the buy side).<sup>33</sup> The AMA has concluded that on the sell side the mergers are likely to result in higher premium levels to health care consumers and/or a reduction in the quality of health insurance that can take the form of a reduction in the availability of providers, a reduction in consumer service, etc. On the buy side, the mergers could enable the merged entities to lower payment rates for physicians such that there would be a reduction in the quality or quantity of the services that physicians are able to offer patients.

### ***Likely Detrimental Effects for Consumers in the Health Insurance Marketplace***

#### **Price Increases**

A growing body of peer-reviewed literature suggests that greater consolidation leads to price increases, as opposed to greater efficiency or lower health care costs.

Two studies have examined the effects of past health insurance mergers on premiums. A study of the 1999 merger between Aetna and Prudential found that the increased market concentration was associated with higher premiums.<sup>34</sup> Most recently, a second study examined the premium impact of the 2008 merger between UnitedHealth Group Inc. and Sierra Health Services. That merger led to a large increase in concentration in Nevada health insurance markets. The study concluded that in the wake of the merger,

<sup>32</sup> Greaney, "The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition," Testimony before the House Committee on the Judiciary, September 22, 2015, at 10.

<sup>33</sup> *U.S. v. Aetna Inc.*, *supra* note 12, at ¶¶ 17-18; *United States v. United Health Group Inc.* No. 1:05CV02436 (D.D.C., Dec. 20, 2005) (complaint), available at [www.usdoj.gov/atr/cases/f213800/213815.htm](http://www.usdoj.gov/atr/cases/f213800/213815.htm).

<sup>34</sup> Leemore Dafny et al, "Paying a Premium on your Premium? Consolidation in the US health insurance industry," *American Economic Review* 2012; 102: 1161-1185.

premiums in Nevada markets increased by almost 14 percent relative to a control group. These findings suggest that the merging parties exploited their resulting market power, to the detriment of consumers.<sup>35</sup>

Also, recent studies suggest premiums for employer sponsored fully insured plans are rising more quickly in areas where insurance market concentration is increasing.<sup>36</sup>

Consistent with the observation that the loss of competition accompanying health insurer mergers results in higher premiums is research finding that competition among insurers is associated with lower premiums.<sup>37</sup> Research suggests that on the federal health insurance exchanges, the participation of one new carrier (i.e., UnitedHealth Group Inc.) would have reduced premiums by 5.4 percent, while the inclusion of all companies in the individual insurance markets could have lowered rates by 11.1 percent.<sup>38</sup> Professor Dafny observes that there are a number of studies documenting lower insurance premiums in areas with more insurers, including on the state health insurance marketplaces, the large group market, and in Medicare Advantage.<sup>39</sup>

### **Medical Loss Ratio Does Not Protect Consumers**

The health insurers claim that medical loss ratio (MLR) regulations will protect consumers from the anticompetitive merger consequences predicted by research. The MLR measures how much of the premium dollar goes to pay for medical claims and quality activities instead of administrative costs and marketing. Large group insurers must devote at least 85 percent of premium revenues-net of taxes and licensing fees to medical claims and quality improvement. (An 80 percent requirement applies to small group/individual plans). However, the MLR requirements do not apply to more than half of Americans under age 65 with health insurance coverage because the rules do not apply to privately-insured enrollees in self-insured plans. Also, as Professor Dafny has observed, for the regulations to constrain an exercise of market power “they must ‘bind:’ the statutory floors must be higher than we would otherwise see.”<sup>40</sup> Thus, there may be substantial room for profitable merger-related price increases in the individual market in particular, notwithstanding the minimum MLR requirement. She further observes that because the MLR is calculated at the state and market level, it is conceivable that mergers can enable insurers to offset low MLRs in one geographic area or sub-segment with high MLR in another.<sup>41</sup> In addition, the MLR does not address the level of the premium increase, only the percentage used for claims and quality activities. Finally, MLR regulation does not address non-price dimensions of health insurer competition such as product design, provider networks, and customer service. Therefore the MLR does not protect consumers from post-merger harm along “value” dimensions.

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<sup>35</sup> Jose R. Guardado, David W. Emmons, and Carol K. Kane, “The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra” *Health Management, Policy and Innovation*, 2013; 1(3) 16-35.

<sup>36</sup> Dafny, *supra* note 15, at 11.

<sup>37</sup> Dafny et al., *supra* note 34.

<sup>38</sup> “More Insurers, Lower Premiums? Evidence from Initial Pricing in the Health Insurance Marketplaces,” *Kellogg Insight* (July 7, 2014), [http://insight.kellogg.northwestern.edu/article/more\\_insurers\\_lower\\_premiums](http://insight.kellogg.northwestern.edu/article/more_insurers_lower_premiums).

<sup>39</sup> Dafny, *supra* note 15, at 11.

<sup>40</sup> Dafny, *Id.*, at 14.

<sup>41</sup> *Id.*

### Plan Quality

The mergers can be expected to adversely affect health insurance plan quality. Insurers are already creating very narrow and restricted networks that force patients to go out-of-network to access care. A merger would reduce pressures on plans to offer broader networks to compete for members and would create fewer networks that are simultaneously under no competitive pressure to respond to patients' access needs. As a result, it is even more likely that patients will find themselves in inadequate networks and be forced to access out-of-network care at some point. Similarly, it is very likely that patients will find themselves at in-network hospitals where, given their restricted network plans, many of the hospitals' physicians will not have been offered a contract by the insurer.

While the relationship between insurer consolidation and plan quality requires additional research, one study in the Medicare Advantage market found that more robust competition was associated with greater availability of prescription drug benefits.<sup>42</sup> As Professor Dafny observes, "the competitive mechanisms linking diminished competition to higher prices operate similarly with respect to lower quality."<sup>43</sup>

### Merger Efficiency Claims are Unsupported and Speculative

Professor Dafny noted in her Senate testimony that claims of offsetting efficiencies cannot ameliorate the competitive harm from these mergers. "Efficiencies must be merger-specific and verifiable...and there is still the question of whether benefits will be passed through to consumers in light of that diminished competition."<sup>44</sup> Insurers have a dismal track record of passing any savings from an acquisition on to consumers, and there is no reason to believe that this transaction would be any different. Under these circumstances, we suggest that the DOJ review the merging insurers' efficiency claims with skepticism similar to that expressed by the Ninth Circuit Court of Appeals in the merger case of *St. Alphonsus Medical Center and Federal Trade Commission v. St. Luke's*, 778 F.3d 775 (9<sup>th</sup> Cir, 2015). ("The Supreme Court has never expressly approved an efficiencies defense to a section 7 claim...We remain skeptical about the efficiencies defense in general and about its scope in particular.")<sup>45</sup>

Turning to the health insurers' specific efficiency claims, "[t]here is no evidence that larger insurers are more likely to implement innovative payment and care management programs...[and] there is a countervailing force offsetting this heightened incentive to invest in...reform: more dominant insurers in a given insurance market are less concerned with ceding market share."<sup>46</sup> In fact, "concerted delivery system reform efforts have tended to emerge from other sources, such as provider systems...and non-national payers," according to Professor Dafny, not commercial health insurers.<sup>47</sup>

In any event, the vague "innovative payment" and "care management" claims made by the health insurers in their Congressional testimony are undermined by the studies of consummated health insurance mergers discussed above, which show that the mergers actually resulted in harm to consumers in the form of higher, not lower, insurance premiums.

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<sup>42</sup> See R. Town and S. Liu, *supra* note 6.

<sup>43</sup> Dafny, *supra* note 15, at 11.

<sup>44</sup> *Id.* at 16.

<sup>45</sup> *St. Alphonsus Medical Center and Federal Trade Commission v. St. Luke's*, 778 F.3d 775, 789-790 (9<sup>th</sup> Cir, 2015)

<sup>46</sup> Dafny, *supra* note 15, at 16.

<sup>47</sup> *Id.*

### Countervailing Power Is Not a Consumer Welfare Enhancing Efficiency

Several scholars have observed that one of the motivations for the health insurer mergers is to respond to hospital consolidation by acquiring countervailing power to force hospital prices down to the benefit of consumers.<sup>48</sup> There is, however, no economic evidence that the formation of bilateral hospital/health insurer monopolies—a battle between proverbial Sumo wrestlers—benefits consumers. Professor Greaney observes that such matches often end in a handshake and consumers get crushed.<sup>49</sup> The better answer to hospital consolidation is to recognize that integrated care does not necessarily require hospital-led consolidation and that by encouraging entry into hospital markets, hospital markets can be made competitive.

Fortunately, regulators can take steps to encourage new entry.<sup>50</sup> Low-hanging fruit in this area would be removing barriers to health care market entry that the government itself has erected. These include strengthening and expanding program integrity exemptions for physicians participating in alternative payment and delivery models, more flexible antitrust enforcement policies to foster physician networks engaged in alternative payment models (APMs) and the elimination of state certificate of need (CON) laws and the ban placed by the ACA on physician-owned specialty hospitals (POH). This latter restriction is radically inconsistent with the general thrust of the ACA, which is to encourage competition, such as the creation of health insurance exchanges and the formation of new delivery systems.

### ***The Health Insurer Monopsony Power Acquired Through the Mergers Would Likely Degrade the Quality and Reduce the Quantity of Physician Services***

Just as the proposed mergers would enable the merged firms to raise premiums or reduce levels of service, they would also be likely to be able to lower payment rates for physicians to a degree that would reduce the quality or quantity of services that they offer to patients such that the mergers would violate section 7 of the Clayton Act.

The DOJ has successfully challenged two health insurer mergers (half of all cases brought against health insurer mergers) based in part on DOJ claims that the mergers would have anticompetitive effects in the purchase of physician services. These challenges occurred in the merger of Aetna and Prudential in Texas in 1999,<sup>51</sup> and the merger of UnitedHealth Group Inc. and Pacific Care in Tucson, Arizona and in Boulder, Colorado in 2005.<sup>52</sup>

In a third merger matter occurring in 2010—Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan—the health insurers abandoned their merger plans when the DOJ complained that

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<sup>48</sup> See Prof. Mark Pauly of the Wharton School at *Health Care Management Professor Mark Pauly PhD Discusses Proposed Health Care Insurance Company Mergers*, available at: <http://knowledge.wharton.upenn.edu/article/whats-driving-health-insurers-merger-mania/>, and Prof. Thomas Greaney, “*Examining Implications of Health Insurance Mergers*,” available at: <http://healthaffairs.org/blog/2015/07/16/examining-implications-of-health-insurance-mergers/>.

<sup>49</sup> Greaney, “*Examining Implications of Health Insurance Mergers*.”

<sup>50</sup> *Id.*

<sup>51</sup> *U.S. v. Aetna Inc.*, supra note 12, at ¶¶ 17-18; *see also U.S. v. Aetna, Inc.*, No. 3-99 CV 1398-H, at 5-6 (Aug. 3, 1999) (revised competitive impact statement), available at <http://www.usdoj.gov/atr/case/s/f2600/2648.pdf>.

<sup>52</sup> *United States v. United Health Group Inc.* No. 1:05CV02436 (D.D.C., Dec. 20, 2005) (complaint), available at: [www.usdoj.gov/atr/cases/f213800/213815.htm](http://www.usdoj.gov/atr/cases/f213800/213815.htm).

the merger “...would have given Blue Cross Michigan the ability to control physician payment rates in a manner that could harm the quality of healthcare delivered to consumers.”<sup>53</sup>

DOJ’s monopsony challenges properly reflect the Agency’s conclusions that it is a mistake to assume that a health insurer’s negotiating leverage acquired through merger is a good thing for consumers. On the contrary, consumers can expect higher insurance premiums.”<sup>54</sup> Health insurer monopsonists typically are also monopolists.<sup>55</sup> Facing little if any competition, they lack the incentive to pass along cost savings to consumers. Also, the demand for health insurance is inelastic—when the price is raised, the insurer’s total revenue increases, and when price falls so do total revenues.<sup>56</sup>

Consumers do best when there is a competitive market for purchasing physician services. This was the well-documented conclusion reached in the 2008 hearings before the Pennsylvania Insurance Department on the competition ramifications of the proposed merger between Highmark, Inc. and Independence Blue Cross. Based on an extensive record of nearly 50,000 pages of expert and other commentary,<sup>57</sup> the Pennsylvania Insurance Department was prepared to find the proposed merger to be anticompetitive in large part because it would have granted the merged health insurer undue leverage over physicians and other health care providers. This leverage would be “to the detriment of the insurance buying public” and would result in “weaker provider networks for consumers who depend on these networks for access to quality healthcare.”<sup>58</sup> The Pennsylvania Insurance Department further concluded:

Our nationally renowned economic expert, LECG, rejected the idea that using market leverage to reduce provider reimbursements below competitive levels will translate into lower premiums, calling this an “economic fallacy” and noting that the clear weight of economic opinion is that consumers do best when there is a competitive market for purchasing provider services. LECG also found this theory to be borne out by the experience in central Pennsylvania, where competition between Highmark and Capital Blue Cross has been good for providers and good for consumers.<sup>59</sup>

For example, compensation below competitive levels hinders physicians’ ability to invest in new equipment, technology, training, staff and other practice infrastructure that could improve the access to, and quality of, patient care. It may also force physicians to spend less time with patients to meet practice expenses. Mergers may also cause even tighter provider networks, reducing patient access to physicians and effectively curtailing the quantity of their services. When one or more health insurers dominate a market, physicians can be pressured not to engage in aggressive patient advocacy, a crucial safeguard of patient care.

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<sup>53</sup> Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans | OPA | Department of Justice, available at:

<http://www.justice.gov/opa/pr/blue-cross-blue-shield-michigan-and-physicians-health-plan-mid-michigan-abandon-merger-plans>.

<sup>54</sup> Dafny, *supra* note 15, at 9. <sup>55</sup> Peter J. Hammer and William M. Sage, *Monopsony as an Agency and Regulatory Problem in Health Care*, 71 ANTITRUST. L.J. 949 (2004).

<sup>55</sup> Peter J. Hammer and William M. Sage, *Monopsony as an Agency and Regulatory Problem in Health Care*, 71 ANTITRUST. L.J. 949 (2004).

<sup>56</sup> Su Liu & Deborah Chollet, *supra* note 39.

<sup>57</sup> See [http://www.ins.state.pa.us/ins/lib/ins/whats\\_new/Excerpts\\_from\\_PA\\_Insurance\\_Dept\\_Expert\\_Reports.pdf](http://www.ins.state.pa.us/ins/lib/ins/whats_new/Excerpts_from_PA_Insurance_Dept_Expert_Reports.pdf) for background information, including excerpts from the experts.

<sup>58</sup> See Statement of Pennsylvania Insurance Commissioner Joel Ario on Highmark and IBC Consolidation (January 22, 2009).

<sup>59</sup> *Id.*

Verifying the threat to consumers, a consumer representative testified in the Senate Judiciary Committee hearing on the mergers that they could “force doctors and hospitals to go beyond trimming costs, to cut costs so far that it begins to degrade the care and service they provide below what consumers value and need.”<sup>60</sup>

Such reduction in service levels and quality of care causes immediate harm to consumers. In the long run, it is imperative to consider whether monopsony power will harm consumers by driving physicians from the market. Health insurer payments that are below competitive levels may reduce patient care and access by motivating physicians to retire early or seek opportunities outside of medicine that are more rewarding, financially or otherwise. According to a 2015 study released by the Association of American Medical Colleges, the U.S. will face a shortage of between 46,000-90,000 physicians by 2025. The study, which is the first comprehensive national analysis that takes into account both demographics and recent changes to care delivery and payment methods, projects shortages in both primary and specialty care.<sup>61</sup> Recent projections by the Health Resources and Services Administration similarly suggest a significant shortage of primary care physicians in the United States.<sup>62</sup>

Moreover, according to a recent survey by Deloitte, six in 10 physicians said it was likely that many physicians would retire earlier than planned in the next one to three years, a perception that Deloitte stated is fairly uniform among all physicians, irrespective of age, gender, or medical specialty.<sup>63</sup> According to the Deloitte survey, 57 percent of physicians also said that the practice of medicine was in jeopardy and nearly 75 percent of physicians thought that the “best and the brightest” may not consider a career in medicine. Finally, most physicians surveyed believed that physicians would retire or scale back practice hours, based on how the future of medicine is changing.<sup>64</sup>

#### ***Monopsony Anticompetitive Effects May be Especially Felt by Consumers and Physicians in The Market for Medicare Advantage***

Mergers resulting in monopsony power within the MA market would likely be felt most acutely by physicians who specialize in providing services to the elderly. With limited capacity to expand their business to traditional Medicare, these physicians may be especially harmed by the exceptionally high degree of concentration in the MA market where the lack of competition enables insurers to depress fees paid to physicians for services under MA.

#### ***DOJ Should Block the Mergers to Protect the Quality and Quantity of Physician Services***

Given that the proposed mergers would result in countless highly concentrated commercial and MA markets where the merged entities either possessed substantial market shares or could exercise buyer power through coordinated interaction, it is critical for antitrust enforcers to oppose the proposed mergers

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<sup>60</sup> Statement of George Slover, Senior Policy Counsel, Consumers Union, Hearing of the Senate Committee on the Judiciary (September 22, 2015), available at: <http://www.judiciary.senate.gov/meetings/examining-consolidation-in-the-health-insurance-industry-and-its-impact-on-consumers>.

<sup>61</sup> See IHS Inc., The Complexities of Physician Supply and Demand: Projections from 2013 to 2025. Prepared for the Association of American Medical Colleges. Washington, DC: Association of American Medical Colleges; 2015.

<sup>62</sup> See health resources and services administration, projecting the supply and demand for primary care physicians through 2020 in brief (November 2013).

<sup>63</sup> Deloitte 2013 Survey of U.S. Physicians: Physician perspectives about health care reform in the future of the medical profession.

<sup>64</sup> Id.

so that physicians have adequate competitive alternatives. Unless successfully opposed, the merged entities would likely be able to lower payment rates for physicians to a degree that would reduce the quality or quantity of services that physicians offer to patients.

#### REMEDIES: DIVESTITURES WOULD BE UNWORKABLE AND INADEQUATE TO PROTECT CONSUMERS

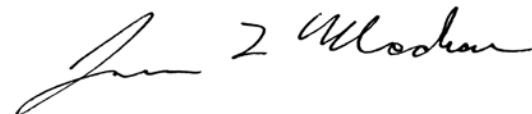
Any remedy short of blocking the mergers would not adequately protect consumers. A divestiture would not protect against the loss of potential competition that occurs when two of the five largest health insurers are eliminated. Moreover, divestiture could be highly disruptive to the marketplace and cause harm to consumers, especially in Medicare Advantage markets where the elderly would be faced with a new insurer.

As a practical matter, the overwhelming number of markets adversely affected by the proposed mergers, along with the barriers to entry to health insurance most recently demonstrated by the failure of the federally subsidized co-op program, makes unlikely that the DOJ could find proposed buyers of assets that could supply health insurance at a cost and quality comparable to that of the merger parties in the huge number of affected markets. Moreover, any qualified purchaser able to contract with a cost competitive network of hospitals and physicians, if found, would likely already be a market participant, and a divestiture to such an existing market participant would not likely return the market to even pre-merger levels of competition.

Also troublesome is the apparent absence of a viable divestiture remedy in a national market where five national insurers compete for employer contracts. There are no would-be purchasers with the size and scope of the existing five national insurers that could replace the lost national competition.

Accordingly, the AMA respectfully urges DOJ to block the mergers in order to protect consumers from premium increases, lower plan quality, and a reduction in the quantity and quality of physician services. We thank the Antitrust Division for its vigilant merger enforcement and look forward to helping augment your analysis with data and insights gleaned from our studies of health insurance markets.

Sincerely,



James L. Madara, MD

By email and Federal Express

February 23, 2016

Ted Nickel  
Commissioner  
Wisconsin Office of the Commissioner of Insurance  
125 South Webster St.  
Madison, WI 53703-3474

Katherine L. Wade  
Commissioner  
State of Connecticut Insurance Department  
153 Market St.  
Hartford, CT 06103

Dear Commissioners Nickel and Wade:

The American Hospital Association (AHA), whose members include nearly 5,000 hospitals, health systems and other health care organizations, and 43,000 individuals, is writing to raise serious concerns about whether provisions in the Affordable Care Act (ACA) that set minimum medical loss ratios (MLRs) and provide rate review standards might, as some have argued, temper the anticompetitive effects that will follow in the wake of the pending mergers of Anthem with Cigna and Aetna with Humana.

The proposed acquisitions would reduce the number of major commercial health insurance companies in the United States from five to just three and would lead to a serious lessening of competition by reducing options available to American consumers in hundreds of markets that already are highly concentrated. As expert economists have shown, previous consolidation of health insurers has led to premium increases.<sup>1</sup> More consolidation will lead to further premium increases, thereby diminishing the promise of affordable health care for all.

We are deeply concerned that the Florida Office of Insurance Regulation's recent approval of the Aetna-Humana merger with very limited remedies was premised, in part, on the Office's

<sup>1</sup> See, e.g., Leemore S. Dafny, *Evaluating the impact of health insurance industry consolidation: learning from experience*, Commonwealth Fund, Issue Brief, November 2015, available at [www.commonwealthfund.org/~media/files/publications/issue-brief/2015/nov/1845\\_dafny\\_impact\\_hlt\\_ins\\_industry\\_consolidation\\_ib.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/nov/1845_dafny_impact_hlt_ins_industry_consolidation_ib.pdf).



acceptance of the argument that medical loss requirements in Florida, and more recently in federal, law effectively limit any entities' ability to exercise market power, independent of market concentration.<sup>2</sup>

As discussed below, that argument does not withstand scrutiny.<sup>3</sup> We believe that state regulators should be extremely skeptical about the validity of such arguments. We urge that you share this letter with all your colleagues on the respective task forces you chair to inform the analyses of the task forces and the regulators in the individual states.<sup>4</sup>

### **The Minimum MLR Standard Will Not Protect Consumers from Higher Premiums**

The ACA's MLR provision is intended to ensure that consumers get value for their premium dollar when purchasing health insurance. The ACA requires an insurer selling in the individual or small group market to use at least 80 percent of each premium dollar to pay for medical care (i.e., claims costs) and quality improvement activities. The minimum threshold for the large group market is 85 percent. Insurers must report their MLRs to the Centers for Medicare & Medicaid Services (CMS), which provides for oversight of insurer compliance and also provides for public disclosure of insurer MLR data. If insurers do not meet or exceed the 80 or 85 percent MLR standard, they are required to pay refunds or rebates to their enrollees. While the MLR has helped improve the value of health insurance products (because the percentage of enrollees in plans meeting the minimum standards has increased each year), for the following reasons it does not create an effective brake on premium increases in concentrated markets:

- About three of every five workers are in plans that are not covered by the ACA's MLR standard (or by any state MLR requirements). This is largely because MLR requirements do not apply to private sector, self-insured health plans. If a self-insured employer plan purchases administrative services and/or stop-loss (reinsurance) coverage from an insurer, the cost of those products is not subject to the MLR constraints.
- The MLR does not address the premium amount. It only requires that a minimum percent of that premium be used for medical claims and quality enhancing activities.

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<sup>2</sup> Florida Office of Insurance Regulation, Report on review of the Aetna Inc.'s acquisition of Humana and affiliates (Feb. 12, 2016) at 20, available at

[www.floir.com/siteDocuments/Report\\_on\\_Review\\_of\\_the\\_Aetna\\_Inc\\_Acquisition\\_of\\_Humana\\_and\\_Affiliates.pdf](http://www.floir.com/siteDocuments/Report_on_Review_of_the_Aetna_Inc_Acquisition_of_Humana_and_Affiliates.pdf).

<sup>3</sup> See also Mark V. Pauly, Ph.D., *The worst of both worlds: mergers like Anthem-Cigna and Aetna-Humana could lead to higher premiums and higher costs*. US News & World Report Policy Dose (July 29, 2015), available at [www.usnews.com/opinion/blogs/policy-dose/2015/07/29/why-health-insurance-mergers-could-mean-higher-premiums](http://www.usnews.com/opinion/blogs/policy-dose/2015/07/29/why-health-insurance-mergers-could-mean-higher-premiums).

<sup>4</sup> An earlier AHA analysis of the why MLR and rate review standards are not a defense to further health plan consolidations can be found on the AHA website at [http://www.advancinghealthinamerica.org/wp-content/uploads/2015/09/Plan-consolidation-MLR-factsheet\\_8-18-15\\_clean.pdf](http://www.advancinghealthinamerica.org/wp-content/uploads/2015/09/Plan-consolidation-MLR-factsheet_8-18-15_clean.pdf) and [http://www.advancinghealthinamerica.org/wp-content/uploads/2015/09/Rate-Review-Factsheet\\_8.27.15\\_final.pdf](http://www.advancinghealthinamerica.org/wp-content/uploads/2015/09/Rate-Review-Factsheet_8.27.15_final.pdf).

- Similarly, the MLR regulations seek to limit insurer profits but would not protect consumers from post-merger harm that would result from the loss of competitors. Insurers may still find it profitable to raise premiums and pay consumers higher rebates in order to retain higher profits. For example, national MLRs in 2013 were 86 percent, 84 percent and 89 percent for the individual, small group and large group markets (compared with the required minimums of 80 percent for individual and small group market and 85 percent large group market floors). This suggests insurers will have room for post-merger price increases while still meeting minimum MLR standards.<sup>5</sup>
- The federal rules for reporting MLRs provide for aggregation at a relatively high level. In general, the MLR is not based on each policy offered by an insurer, but on the insurer's annual aggregate performance within each market (individual, small group or large group) and state.<sup>6</sup> This broad application of the MLR, as required by the ACA's implementing regulations, can mask potentially wide differences in the return on premium for an insurer's different health insurance products. Consequently, the MLR does not provide a limit on the ability of an insurer to offer specific products that fail to meet the minimum MLR threshold.
- Some insurers may get around the MLR requirements in ways that will enable them to increase premiums. Labeling profits as costs is one possibility; an insurer could create a separate quality improvement arm and charge that arm fees that offset profits exceeding the MLR minimum standard.<sup>7</sup>
- The ACA allows insurers to classify expenses for certain quality improvement activities as clinical benefits and count them as medical claims. To raise their MLRs, some insurers may identify some administrative costs as quality improvement expenses. Although CMS has provided detailed guidance on reporting requirements for quality improvement expenses, there is likely still some room for reclassification of costs.
- Resource constraints limit the ability of CMS to provide much oversight of insurers' MLR reporting. CMS can only do a detailed review of issuer MLR reporting compliance for a small number of insurers each year.

## Rate Review Standards

In addition to the ACA's MLR standards, some argue rate review will apply pressure on insurers to hold down rate increases. Under the ACA's federal rate review standard, health insurance carriers are required to file and publicly justify proposed rate increases of 10 percent or more.

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<sup>5</sup> Dafny, *supra*, Note 1; Robert Book, *How the Medical Loss Ratio Requirement Could Increase Health Insurance Premiums and Insurer Profits at Taxpayer Expense* (April 2013), available at [http://americanactionforum.org/uploads/files/research/MLR\\_Paper\\_Final.pdf](http://americanactionforum.org/uploads/files/research/MLR_Paper_Final.pdf).

<sup>6</sup> A loss ratio computed separately for an insurer's specific book of business would be subject to more volatility due, for example, to unexpected utilization changes than would a measure across the insurer's entire book of business.

<sup>7</sup> Dafny, *supra*, Note 1.

States – typically, through their insurance departments – may provide for additional review of health insurance carriers’ rates.

Most states review rates that have been filed but do not require the rates be approved before insurers can charge them (“file and use”). Some states require the insurer to obtain “prior approval” of their rates and may require an insurer to change its rates in order to be able to sell the policy. While rate review has the potential to slow the rate of premium increases, its effect is likely to be modest unless the state goes a step further and actually *regulates* the rates that insurers charge. Moreover:

- Federal rate review is not universal. It only applies to non-grandfathered plans offered in the small and individual markets and, in most states, to non-association sponsored health plans. In 2011, when the Department of Health and Human Services (HHS) issued the final rate review rule, it estimated that 35 million people would be covered by products subject to rate review. That represented about 17 percent of the commercial market for health insurance.<sup>8</sup>
- The federal rate review process does not preempt states’ own rate review laws or procedures. As a result, the wide variation in the effectiveness of states’ processes has continued post-ACA. State processes continue to vary with respect to the authority each state gives its insurance department to reject or revise proposed rates.<sup>9</sup>
- Some states may not support strong rate review even if the insurance department has the authority to reject or modify rates.<sup>10</sup>
- In states that have not been identified by HHS as having effective review processes, HHS has been slow to make rates transparent. And, importantly, although HHS may take into account recommendations by state regulators about excessive or unjustified rate increases in determining which plans may be offered as Qualified Health Plans through health insurance exchanges, HHS does not have the authority to reject rates.<sup>11</sup>
- In some states, rate review results in *higher*, not lower rates. The Commonwealth Fund reported last year several examples of states that urged insurers to raise rates even more than insurers proposed.<sup>12</sup>

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<sup>8</sup> Final Rule with Comment Period: Rate Increase Disclosure and Review, 76 *Federal Register* 29964 - 29988, available at <http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf>.

<sup>9</sup> Available at <http://consumersunion.org/wp-content/uploads/2014/04/Exhibit-A-State-List-Public-Participation.pdf>; <http://www.healthcaredive.com/news/state-rate-regulation-is-there-one-future-or-50/391431/>.

<sup>10</sup> Reed Abelson, Health insurers raise some rates by double digits. *The New York Times* (Jan. 5, 2013), available at [http://www.nytimes.com/2013/01/06/business/despite-new-health-law-some-see-sharp-rise-in-premiums.html?\\_r=0](http://www.nytimes.com/2013/01/06/business/despite-new-health-law-some-see-sharp-rise-in-premiums.html?_r=0).

<sup>11</sup> ACA addresses our long history of premium rate hikes. *The Hill*, Congress Blog (June 16, 2014), available at <http://thehill.com/blogs/congress-blog/healthcare/209330-aca-addresses-our-long-history-of-premium-rate-hikes>.

<sup>12</sup> Proposed premium rate increases for 2016: the jury is still out. *The Commonwealth Fund Blog* (July 21, 2015), available at [www.commonwealthfund.org/publications/blog/2015/jul/proposed-premium-rate-increases-for-2016](http://www.commonwealthfund.org/publications/blog/2015/jul/proposed-premium-rate-increases-for-2016).

The Honorable Ted Nickel  
The Honorable Katherine Wade  
February 23, 2016  
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- Rate filings are not readily understood by consumers and in some states are not made easily accessible.

Should you have any additional questions, please feel free to contact me directly at  
[mhatton@aha.org](mailto:mhatton@aha.org) or (202) 626-2336.

Sincerely,

/s/

Melinda Reid Hatton  
Senior Vice President & General Counsel

**TESTIMONY OF LEEMORE S. DAFNY, Ph.D**

**Professor of Strategy**

**Herman Smith Research Professor of Hospital and Health Services  
Director of Health Enterprise Management  
Kellogg School of Management  
Northwestern University**

**Before the**

**Senate Committee on the Judiciary**

**Subcommittee on Antitrust, Competition Policy, and Consumer Rights**

**On**

**“Health Insurance Industry Consolidation:  
What Do We Know From the Past, Is It Relevant in Light of the ACA, and  
What Should We Ask?”**

September 22, 2015

## Summary

Nearly two-thirds of the U.S. population under age 65 is enrolled in a private, comprehensive health insurance plan.<sup>1</sup> The private health insurance industry is also playing an increasingly important role in supplying coverage to enrollees in public insurance programs. The public interest in a competitive, robust marketplace has never been greater. Not only are private insurance premiums (\$16,834 for the average family) and out of pocket spending (\$800 per person)<sup>2</sup> high and projected to grow, but the individual health insurance mandate now requires those without public coverage to purchase private policies. Federal subsidies for the purchase of private insurance through the health insurance marketplaces are projected to total \$32 billion in 2015, and \$84 billion by 2020.<sup>3</sup> Given these stakes, there is a substantial public benefit to critically evaluating any significant changes in industry market structure.

There are two primary and complementary ways to assess the impact of consolidation: backward-looking (what has happened in the past?) and forward-looking (what is different, if anything, and how might those differences alter predictions based on the past?). This testimony addresses both. First, I review economic studies on the impact of insurance consolidation on premiums and other outcomes of potential interest to consumers. These studies suggest that consolidation leads to premium increases. This is true notwithstanding the growing body of research that finds insurers with larger local market shares pay lower rates to healthcare providers, particularly hospitals.<sup>4</sup> As I discuss below, lower provider rates can, under certain circumstances, also harm consumers directly. The evidence on the link between insurance market concentration and health plan quality is sparse, but at least one study suggests benefit generosity declines with fewer competitors.<sup>5</sup>

In sum, economic research demonstrates that insurance industry consolidation in the past has not tended to improve the lot of consumers. Any individual proposed merger may have different

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<sup>1</sup> National Center for Health Statistics, "Early Release of Selected Estimates Based on Data From the National Health Interview Survey, 2014," Table 1.2b, available at <http://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201506.pdf>.

<sup>2</sup> Kaiser Family Foundation and Health Research & Educational Trust, *2014 Survey of Employer Health Benefits*, available at <http://kff.org/health-costs/report/2014-employer-health-benefits-survey>; Health Cost Institute, 2013 *Health Care Cost and Utilization Report*, available at <http://www.healthcostinstitute.org/2013-health-care-cost-and-utilization-report>.

<sup>3</sup> Congressional Budget Office, *Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline*, March 2015, available at <https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf>.

<sup>4</sup> I discuss the evidence on this point below.

<sup>5</sup> Robert Town and Su Liu, "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* (2003): 719-736.

effects and should be evaluated on its own potential merits, however these merits should be assessed with the context provided by this academic, refereed body of literature.<sup>6</sup>

Proponents of continued industry consolidation have introduced two primary arguments for why the existing research is not prescriptive in the post-ACA era. The first is that the Medical Loss Ratio (MLR) regulation<sup>7</sup> prevents merging insurers from reaping profits that might otherwise be possible as a result of a post-merger increase in market power. Essentially, this amounts to a claim that the MLR regulation provides a substitute for competition. There are a number of reasons to doubt this supposition. Chief among them: the MLR regulation does not pertain to the majority of privately-insured Americans, who are enrolled in self-insured plans (which are exempt from the regulation)<sup>8</sup>; it does not adequately address non-price competition; it is likely “gameable”; and the legislated minima may be below prevailing MLRs in certain markets and have no impact at all.

The second argument is subtle, and embraced to a greater extent by economists than industry: insurers with larger local market share have stronger incentive to invest in changing the healthcare delivery system through payment innovations because they can reap more of the rewards from their local investments. At the same time, providers can spread their costs of collaborating on these innovations across more lives. Although this argument has merit, there is also an important countervailing effect of size. An insurer with stronger market power has less of an incentive to invest in new products as it “replaces itself” in the market, i.e. there is less potential to “steal business” from rivals. In addition, there is no research showing that larger insurers are likelier to innovate.

In sum, I see no reason the evidence from the past should be discounted when evaluating current and future consolidation. I would also caution that consolidation that occurs now is unlikely to be undone if it later proves anticompetitive. History also suggests that vigorous competition by new entrants is unlikely to arise and offset such effects.

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<sup>6</sup> As the Horizontal Merger Guidelines state, merger analysis “is a fact-specific process.” U.S. Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines*, 2010, available at <http://www.ftc.gov/os/2010/08/100819hmg.pdf>.

<sup>7</sup> The ACA requires health insurers to maintain an MLR, defined as the proportion of premium revenues spent on clinical services and quality improvement, above 80% for fully-insured individual and small group plans and 85% for fully-insured large group plans. An insurer falling short of these minima must provide rebates to policyholders such that the MLR meets the prescribed level. *See, e.g.*, Center for Consumer Information & Insurance Oversight, “Medical Loss Ratio: Getting Your Money’s Worth on Health Insurance,” Dec. 2, 2011, available at <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/mlrfinalrule.html>.

<sup>8</sup> Approximately 54% of privately insured Americans are exempt from MLR requirements. (This figure is derived as the product of the share of privately insured Americans with employer-sponsored coverage—88 percent—and the share of covered workers enrolled a plan that is completely or partially self-funded—61 percent.) Kaiser Family Foundation and Health Research & Educational Trust, *2014 Survey of Employer Health Benefits*, available at <http://kff.org/health-costs/report/2014-employer-health-benefits-survey>. Kaiser Family Foundation, “Health Insurance Coverage of the Total Population,” 2015, accessed Sep. 9, 2015, <http://kff.org/other/state-indicator/total-population>.

My testimony concludes with a call for sunshine. It is unlikely that consolidation is “inherently bad” or “inherently good”; we need research that reveals how to protect against harms and unlock benefits. Current and historical data on various aspects of commercial health insurance (e.g., enrollment and costs) at a disaggregated level (e.g., by specific health plan, customer segment, and sub-state geographic market, such as the MSA) would enable research that would help us to understand whether and where consolidation is harmful or beneficial, and for whom. While such transparency is rare in many private industries, it is common where there is a strong public interest and substantial public regulation, both of which characterize this vital sector.

## **1. Concentration in the Health Insurance Industry Is High and Growing**

### *1.1 Private Health Insurance Plans*

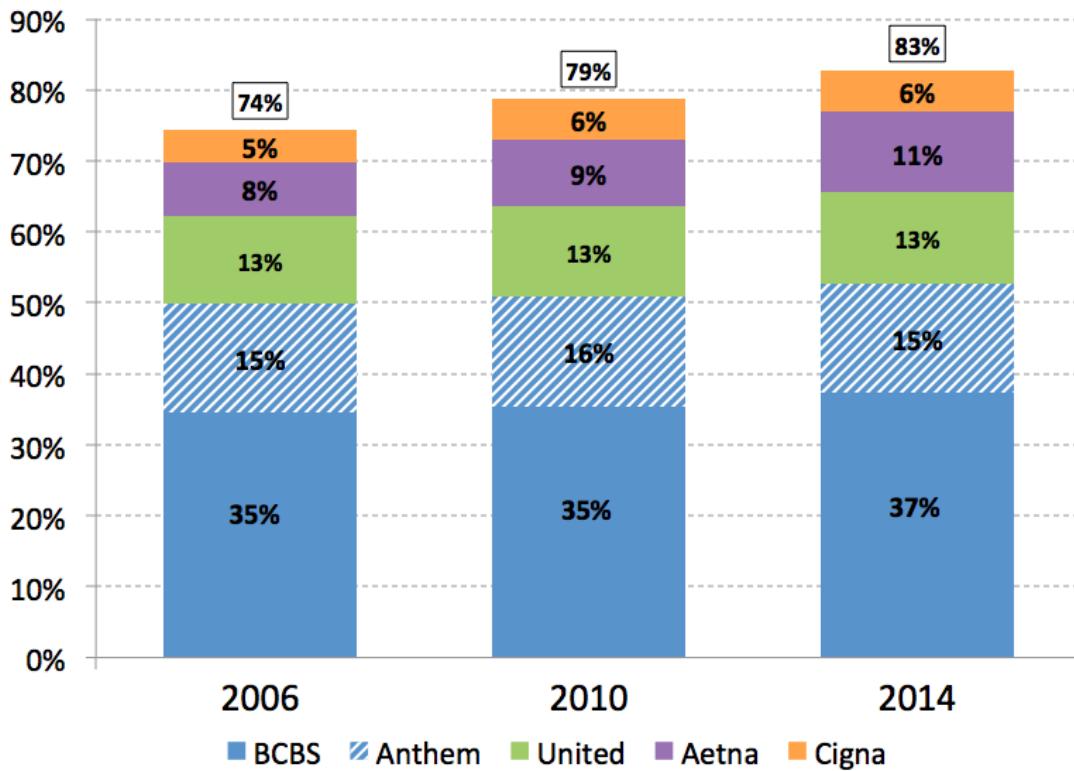
Roughly 175 million Americans under age 65 purchased private insurance through their employers or via the individual insurance market in 2013, the most recent year for which data are available.<sup>9</sup> The industry has expanded since the introduction of the health insurance marketplaces in 2014.

Figure 1 contains my rough estimates of the national market share of the four largest insurers over the period 2006–2014. For most customers – national multisite employers being the primary exception – insurance markets are local, but these share estimates provide context for the changing landscape. In the figure, all 36 Blue Cross and Blue Shield (BCBS) companies are grouped together. With a few exceptions, BCBS affiliates have exclusive, non-overlapping market territories, and hence do not compete with one another. Shares for Anthem, Inc., the for-profit insurer (previously known as Wellpoint) that today operates BCBS plans in 14 states, are denoted separately.

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<sup>9</sup> Per the U.S. Census Bureau’s 2013 Current Population Survey (CPS) Annual Social and Economic (ASEC) Supplement, Table H101, available at [https://www.census.gov/hhes/www/cpstables/032014/health/h01R\\_000.htm](https://www.census.gov/hhes/www/cpstables/032014/health/h01R_000.htm).

**Figure 1. Estimated National Market Shares of 4 Largest Insurers, 2002–2014<sup>10</sup>**



The national four-firm concentration ratio (the sum of the leading four firms in terms of market share) for the sale of private insurance increased significantly between 2006 and 2014, from 74 to 83 percent. As a point of comparison, the four-firm concentration ratio for airlines is 62 percent.<sup>11</sup> BCBS affiliates collectively account for over half of privately-insured lives today, a position they have held throughout this period (following growth during the first half of the 2000s, not pictured). The figure also reflects some of the more significant mergers among non-BCBS insurers in recent history, including the acquisition of Coventry by Aetna (in 2013).

<sup>10</sup> Figure 1 is constructed using the number of privately-insured lives reported in each insurer's annual reports. Consistency over time and across insurers in terms of products included is not assured. BCBS share (exclusive of Anthem) is estimated using enrollments reported by BCBS for 2010 and 2014, and extrapolating back to 2006 by applying the growth rate in BCBS enrollments from data supplied by the National Association of Insurance Commissioners (NAIC), and corrected for states not reporting or underreporting BCBS enrollment. The BCBS association reports total enrollment of 100 million in 2010 and 106 million in 2014 and may include non-comprehensive insurance. Unfortunately, NAIC reflects only fully-insured plans outside of California, whereas Figure 1 includes both full and self-insurance for all states. Anthem operates BCBS affiliates in CO, CT, KY, ME, NH, NV, OH, VA, IN, GA, MI, WA, CA, and NY. National market size in each year is the number of privately-insured lives, as estimated from the Current Population Survey. Current Population Survey, "Total people with private health insurance," 2002–2013, available at <http://www.census.gov/cps/data/cpstablecreator.html>.

<sup>11</sup> U.S. Department of Transportation Bureau of Transportation Statistics, "Airline Domestic Market Share July 2014–June 2015," available at <http://www.transtats.bts.gov/>.

Figure 1 does not necessarily reflect the degree of concentration in insurance markets that are relevant to most consumers. Commercial health plans are generally offered and priced differently for each customer segment (e.g., individual, small group, large group-fully insured, large group-self-insured – and perhaps others) in different geographic areas. These areas are generally smaller than the state (e.g., metropolitan and/or micropolitan statistical areas or ratings areas as defined for the state health insurance marketplaces).<sup>12</sup> There are many health plans with a significant local, but not a national, presence - Kaiser, Intermountain, and Geisinger among them. The degree of competition in any product and geographic market depends on the relevant market participants (current and potential), and on the characteristics of the plans they offer (or might offer).

The American Medical Association publishes an annual report containing commercial insurance market shares for the top 2 insurers, as well as corresponding market Herfindahl index (HHI), in 388 metropolitan statistical areas (MSAs). These reports show that concentration is generally higher within local markets than in the nation as a whole: the median population-weighted two-firm concentration ratio for 2012 is 0.65. Concentration within MSAs also appears<sup>13</sup> to be increasing over time. The median HHI increased from 1,716 in 2001 to 2,973 in 2012, well in excess of the threshold for “highly concentrated” (2,500) per the *Horizontal Merger Guidelines* issued jointly by the Department of Justice and the Federal Trade Commission.<sup>14</sup>

### 1.2 Medicare Advantage

There are nearly 22 million Medicare beneficiaries enrolled in Medicare Advantage plans of various kinds.

Figure 2 presents the market shares of the four leading providers of Medicare Advantage plans in from 2007 to 2015. Again, these shares are provided for context and may not reflect market structure at the local level at which Medicare beneficiaries make plan selections. The four-firm concentration ratio increased markedly between 2011 and 2015, rising from 48 to 61 percent. The Medicare Advantage market has experienced significantly more turbulence than the private insurance sector, owing to myriad changes in regulations and reimbursement rules.<sup>15</sup> The

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<sup>12</sup> For example, plans offered on the Health Insurance Marketplaces are priced at the rating area level. Rating areas are defined as one or more counties and are generally smaller than MSAs. See, e.g., Kaiser Family Foundation, “Medicare Advantage,” Jun. 29, 2015, accessed Sep. 9, 2015, <http://kff.org/medicare/fact-sheet/medicare-advantage>. CMS Center for Consumer Information and Consumer Oversight, “Market Rating Reforms,” May 28, 2014, accessed Sep. 9, 2015, <https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/state-gra.html>.

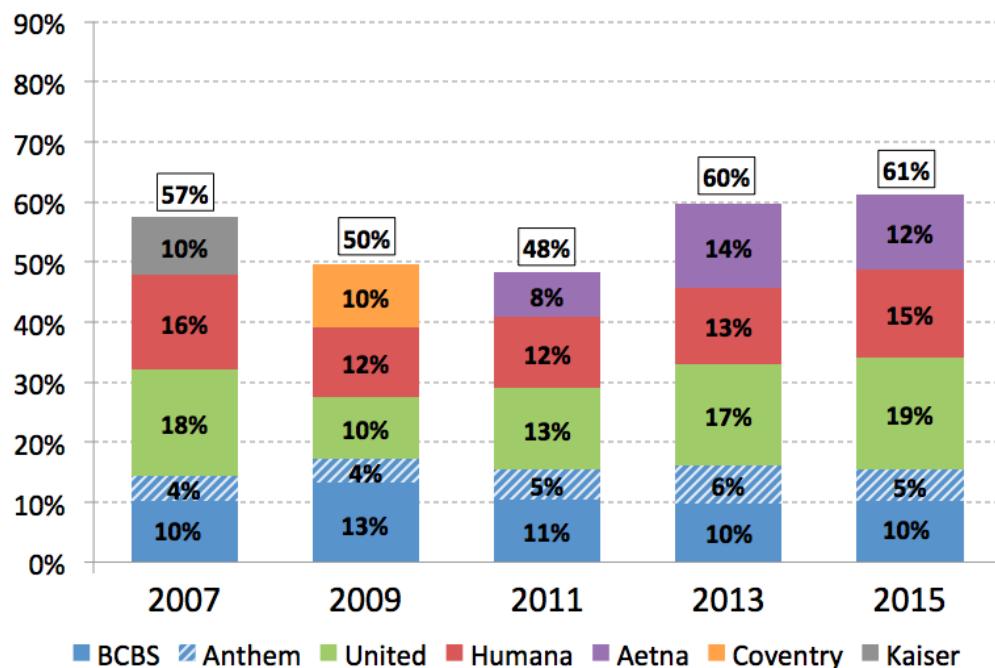
<sup>13</sup> The AMA reports are not strictly comparable over time due to changes in the number of MSAs included, and the inclusion of self-insured lives. The figures for 2012 include self-insured lives.

<sup>14</sup> U.S. Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines*, 2010, available at <http://www.ftc.gov/os/2010/08/100819hmg.pdf>.

<sup>15</sup> Total enrollment in Medicare Advantage has increased significantly over this period, from 9.3 million in 2007 to 22 million in 2015. Duggan, Starc and Vabson (2014) show that reimbursement is strongly linked to entry. They

national market leaders for Medicare Advantage are a bit different from those in the private insurance market (in Figure 1), although they are the same as the market leaders in the fully-insured segment of private insurance.<sup>16</sup>

**Figure 2. Medicare Advantage 4-firm Concentration Ratio, 2007–2015<sup>17</sup>**



Most of the research on insurance consolidation utilizes data from private insurance plans, hence my testimony focuses on this set of customers. Although Medicare Advantage and other health insurance products such as Medicaid Managed Care plans are clearly different – e.g., they face different regulatory requirements, and different challenges with regard to assembling provider networks and negotiating competitive provider rates – the insights from private insurance markets are clearly relevant in light of the similarities in the “production process” for insurance, as evidenced by the significant overlap in the suppliers across the different market types.

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estimate that for every dollar of additional reimbursement from the Medicare program, 20 cents is passed through to enrollees in the form of better coverage. Mark Duggan, Amanda Starc, and Boris Vabson, “Who Benefits When the Government Pays More? Pass-through in the Medicare Advantage Program,” No. w19989, National Bureau of Economic Research, 2014.

<sup>16</sup> In 2013, these are United (14 percent), Anthem (11 percent), Aetna (7 percent) and Humana (4 percent). Source: 2013 CCIIO MLR data, available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

<sup>17</sup> Source: Centers for Medicare and Medicaid Services, Medicare Advantage Enrollment Data, 2007–2015, available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html>.

### 1.3 Drivers of Industry Consolidation

Industry consolidation arises from two sources: structural (i.e., entry, exit, and mergers), and non-structural (i.e., growth or decline of incumbent firms). There is little research on the relative contribution of each to rising concentration.<sup>18</sup> Most of the structural change has been driven by mergers, and the most significant non-structural development appears to be the growth in the market shares of the various BCBS affiliates.<sup>19</sup>

Insurance mergers over the past 20 years can be characterized by four phenomena: (1) attempts by regional insurers to gain broader service areas; (2) attempts by national insurers to obtain a presence in virtually all geographies; (3) acquisitions of local HMOs and provider-sponsored plans by incumbents; (4) consolidation of for-profit BCBS affiliates (into Anthem). Reported motivations include a desire to achieve economies of scale in administration, sales, and marketing; to achieve economies of scale (more lives) and scope (more product lines) with respect to pioneering novel care management and shared savings programs; to strengthen the insurer's negotiating position vis a vis providers (who are themselves growing more concentrated); and to diversify across revenue sources (e.g., government and non-government-insured lives). It is possible that the most recent merger wave is a "contagion" ignited by the announcement of some large acquisitions; to the extent that an insurer is contemplating a merger, learning of other suitors is a motivator to act quickly.

Some have posited that recent or proposed insurance mergers are the result of the Affordable Care Act (ACA). However, the figures above reveal consolidation was well underway before the ACA was passed. It is worth noting that, to the extent such consolidation is anticompetitive, it is at cross-purposes with the Act. As Professor Thomas Greaney recently observed in testimony before the House Subcommittee on Regulatory Reform, Commercial and Antitrust Law, the ACA "does not regulate prices for commercial health insurance or prices in the hospital, physician, pharmaceutical, or medical device markets. Instead the law relies on (1) competitive bargaining *between* payers and providers and (2) rivalry *within* each sector to drive price and quality to levels that best serve the public."<sup>20</sup>

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<sup>18</sup> Scanlon et al. (2005) find that non-structural fluctuations in enrollment accounted for more than one-third of the change in MSA-level HHI between 1998 and 2002. Scanlon, Chernew, Swaminathan, and Lee, "Competition in Health Insurance Markets: Limitations of Current Measures for Policy Analysis," *Medical Care Research and Review*, Vol. 63 No. 6, (Supplement to December 2006) 37S-55S. The insurer HHI data pertain only to HMOs.

<sup>19</sup> This growth precedes the period depicted in Figure 1. Per Ginsburg (2005), "the relative position of the Blues strengthened with the loosening of managed care because of the diminishing importance of HMOs, which were generally a weak point for the Blues. Blue plans' ability to negotiate lower rates with providers on the basis of their large market share became more important." Paul Ginsburg, "Competition in Health Care: Its Evolution Over the Past Decade," *Health Affairs* 24.6 (2005): 1512-1522.

<sup>20</sup> Thomas L. Greaney, "The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition," United States House of Representatives Committee on the

In fact, the Act *promotes* competition in the insurance industry in several ways, including via regulatory reforms (e.g., product standardization and plan certification, which reduce the hurdle to entry posed by the need to establish a credible reputation) and via the health insurance marketplaces (which reduce marketing and sales costs, thereby raising the likelihood of entry). The Health Insurance Marketplaces were explicitly designed to facilitate competition among insurers. The notion that the ACA's MLR regulations, which place a floor on the share of premiums devoted to medical spending and quality improvement activities, provoke consolidation is inconsistent with profit-maximizing behavior. To the extent that scale reduces administrative costs, insurers would have benefited from such reductions in the absence of the regulation.

Even if the ACA *inadvertently* provoked consolidation – perhaps because of a surge of investor interest in growing private insurance markets, and the thirst for higher company valuations – the question before the committee today is whether this phenomenon is likely to be beneficial to consumers. To answer it, I begin by summarizing the empirical evidence on the effects of insurance consolidation.

## 2. What have we learned from the past?

*2.1 If past is prologue, insurance consolidation will tend to lead to lower payments to healthcare providers, but those lower payments will not be passed on to consumers. On the contrary, consumers can expect higher insurance premiums.*

### 2.1.1 Effects of consolidation on healthcare provider prices and health plan quality

Several health economists have studied the correlation between insurance market structure, typically measured by insurer HHI at the MSA level, and hospital prices.<sup>21</sup> Using different data sources and time periods, these studies generally find hospital prices are lower in areas with higher insurance HHIs (typically measured at the MSA level). This relationship also holds when

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Judiciary, Subcommittee on Regulatory Reform, Commercial and Antitrust Law, Sep. 10, 2015, available at [http://judiciary.house.gov/\\_cache/files/0a0e88c8-0519-4a47-8fa8-4c2233c760c3/greaney-testimony.pdf](http://judiciary.house.gov/_cache/files/0a0e88c8-0519-4a47-8fa8-4c2233c760c3/greaney-testimony.pdf).

<sup>21</sup> Glenn A. Melnick et al., "The Increased Concentration of Health Plan Markets Can Benefit Consumers through Lower Hospital Prices," *Health Affairs*, 30, no. 9 (2011): 1728–1733; Asako S. Moriya, William B. Vogt, and Martin Gaynor, "Hospital Prices and Market Structure in the Hospital and Insurance Industries." *Health Economics, Policy and Law* 5.04 (2010): 459-479.; and Erin E. Trish, and Bradley J. Herring, "How do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums?" *Journal of Health Economics*, 42 (2015): 104-114. All three rely on estimates of insurer HHI calculated from InterStudy data. Melnick et al. find that hospital prices in 2001–2004 are lower in MSAs with higher insurer HHI, provided the insurer HHI exceeds 3,200. Moriya et al. find that increases in MSA-level insurer HHI between 2001 and 2003 are associated with decreases in hospital prices. Trish and Herring use more recent data (from 2006–2011) and find that hospital prices are lower among more concentrated insurance markets.

researchers study *changes* over time, i.e., areas experiencing faster growth in insurer HHI exhibit slower growth in hospital prices.

Lower prices for healthcare services will only benefit consumers if – and only if – they are ultimately passed through to consumers in the form of lower insurance premiums (and/or out-of-pocket charges); I discuss the lack of evidence for this pass-through below. However, it is worth noting that even if price reductions are in fact realized *and* passed through, if they are achieved as a result of monopsonization of healthcare service markets then consumers may experience an offsetting harm. Monopsony is the mirror image of monopoly; lower input prices are achieved by reducing the quantity or quality of services below the level that is socially optimal.<sup>22</sup>

There are a handful of studies that directly study monopsony. One study (of which I am a coauthor) finds such evidence in the wake of the Aetna and Prudential merger of 1999.<sup>23</sup> Post-acquisition, the combined entity covered 21 million lives. In the three-year period following the merger, we found relative reduction in healthcare employment and wages in those geographic areas where the two parties had more substantial pre-merger overlap. The implication is that the exercise of market power vis-a-vis healthcare providers reduced price *and* output – the hallmark of monopsony. Indeed, the DOJ had required Aetna and Prudential to divest health plans in two Texas markets before closing precisely because of concerns over post-merger monopsony power. This remedy proved effective: we found no evidence of monopsony in these markets following the merger.<sup>24</sup>

Whether monopsony is likely in the face of consolidation depends on the provider market in question. The textbook monopsony scenario described above pertains when there is a large buyer and fragmented suppliers, as is the case for physicians in some specialties within a given geographic area negotiating with dominant insurers. However, in settings where both sides possess market power and they 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 focus on hospitals – an industry that is concentrated in many

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<sup>22</sup> The way in which a monopsonistic insurance sector would achieve lower reimbursement rates is by setting a low market reimbursement rate, one which is beneath the value that some consumers place on those services. That is, there will be excess demand by consumers for services at this rate, and the monopsonist does not allow price to rise to expand output and equilibrate demand and supply.

<sup>23</sup> Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, “Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry,” *American Economic Review*, 2012, 102(2): 1161–1185.

<sup>24</sup> The formal complaint alleged the merger “would enable Aetna to exercise monopsony power against physicians, allowing Aetna to depress physicians’ reimbursement rates in Houston and Dallas, likely leading to a reduction in quantity or degradation in quality of physicians’ services”. U.S. vs. Aetna Inc. (ND TX, 21 June 1999)

areas – and they find areas with higher insurer HHI have higher, not lower, hospital utilization.<sup>25,26</sup>

In sum, there is some empirical evidence that consumers may be harmed as a result of lower payments to healthcare *personnel*, however more research is needed on this subject.

There is very little published research on the link between consolidation and plan quality. The most relevant study to date pertains to the Medicare Advantage market. The study found that the availability of prescription drug benefits (before the enactment of Part D) was higher in areas with more rivals, all else equal.<sup>27</sup> There is a vast literature in other healthcare settings – e.g., hospitals – showing that quality does not improve when markets become more consolidated.<sup>28</sup> Although quality is often more difficult to evaluate than price, the competitive mechanisms linking diminished competition to higher prices operate similarly with respect to lower quality.

### 2.1.2 Insurance Premiums

There are a number of studies documenting lower insurance premiums in areas with more insurers, including on the state health insurance marketplaces,<sup>29</sup> the large group market (self- and fully-insured combined),<sup>30</sup> and Medicare Advantage.<sup>31</sup> A recent study suggests premiums for employer-sponsored fully-insured plans are increasing more quickly in areas where insurance market concentration is rising, controlling for other area characteristics such as the hospital market concentration.<sup>32</sup>

Arguably the most relevant research in light of the recent proposed mergers are two studies of consummated mergers. Both found that structural changes in market concentration led to higher insurance premiums. The first is the previously-mentioned study of the Aetna-Prudential merger

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<sup>25</sup> Feldman and Wholey (2001) present evidence that prices are lower, but hospital utilization (a measure of quantity) is higher in markets with less competitive insurance markets. Similarly, McKellar et al. (2014) find in more concentrated insurer markets, health care prices are lower, utilization is higher, but overall spending is lower.

<sup>26</sup> It is worth noting that many health policy experts believe some types of health care services are overutilized.

Where true, a quantity reduction arising from the exercise of monopsony power might be viewed as beneficial. However, this paternalistic approach to consumption is not ordinarily adopted by antitrust enforcers.

<sup>27</sup> Robert Town and Su Liu, "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* (2003): 719-736.

<sup>28</sup> See, for example, Gaynor, M. and R. Town (2012), "The Impact of Hospital Consolidation," available at <http://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html>

<sup>29</sup> Steven Sheingold et al., ASPE Issue Brief, "Competition and Choice in the Health Insurance Marketplaces, 2014-2015: Impact on Premiums," U.S. Dept. of Health and Human Services, July 27, 2015, available at <http://aspe.hhs.gov/basic-report/competition-and-choice-health-insurance-marketplaces-2014-2015-impact-premiums>.

<sup>30</sup> Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan. *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*. No. w15434. National Bureau of Economic Research, 2009.

<sup>31</sup> Zirui Song, Mary Beth Landrum, and Michael E. Chernew, "Competitive Bidding in Medicare: Who Benefits From Competition?" *The American Journal of Managed Care* 18.9 (2012): 546.

<sup>32</sup> Trish and Herring (2015). *Ibid.*

of 1999. Using detailed data on health insurance plans sponsored by large, mostly multi-site employers representing roughly 10 million lives, my coauthors and I found that premiums increased significantly more in areas with greater pre-merger overlap. Importantly, we were able to control for changes over time in the average premium for any given employer, so that these changes reflect relative differences across markets for the same firm. Moreover, premium increases were observed not just for the merging firms but for their rivals (in areas where the merging firms had substantial overlap). Thus, even though this particular merger was linked to lower healthcare personnel wages and employment, the cost savings were not passed on to consumers.

We used the estimate from the above paper to predict the impact of all (structural and non-structural) consolidation over the period 1998-2006. We estimate that large group premiums in 2007 were 7 percent (roughly \$200 per person) higher than they would have been had local market concentration remained at its initial level. Although this is a small figure relative to the aggregate premium increase during the same period, it is large compared to typical operating margins of insurers – implying substantial consolidation-induced growth in profits.

A second study, Guardado et al. (2013), examined the effect of the 2008 merger between Sierra Health Services and United on small group premiums in two Nevada markets. As compared to control cities in the South and West, small group premiums in these markets increased by 13.7 percent the year following the merger.<sup>33</sup>

## *2.2 There are substantial barriers to entry in the private health insurance industry, and consolidation-induced premium increases have not generally been offset by competition from new entrants.*

Over the past few decades, the private health insurance industry has seen relatively little entry by new firms. Barriers to entry include: (1) building networks of local providers and negotiating competitive reimbursement rates;<sup>34</sup> (2) establishing a credible reputation with area employers and consumers; (3) developing relationships with brokers, who serve as intermediaries for most purchasers; (4) achieving economies of scale in information technology, disease management, utilization review, and customer-service related functions. “Entry” into a given geographic market has tended to occur via acquisition. To wit, the most likely potential entrants in a market are incumbents in other product and/or geographic markets.<sup>35</sup> In light of the impediments to de

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<sup>33</sup> Jose R. Guardado, David W. Emmons, and Carol K. Kane, “The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra” *Health Management, Policy and Innovation*, 2013: 16–35.

<sup>34</sup> This is a particularly salient barrier due to the “chicken and egg problem” of insurer-provider negotiations. Providers are generally willing to offer the most competitive rates to insurers with a large market share, however to gain market share an insurer needs to offer low premiums (and to do so sustainably, must have competitive provider rates).

<sup>35</sup> For example, recent entry in the private individual insurance market – sparked by the introduction of the Health Insurance Marketplaces and the individual mandate to carry insurance – has largely consisted of firms offering

novo entry, consolidation even in non-overlapping markets reduces the number of potential entrants who might attempt to overcome price-increasing (or quality-reducing) consolidation in markets where they do not currently operate.

### **3. How relevant is what we have learned in light of changes arising from the Affordable Care Act?**

#### *3.1. Applicability of merger retrospectives*

A reasonable question to ask is whether the previously described retrospective analyses (of the Aetna-Prudential and United-Sierra mergers) are informative in light of the significant recent changes in the healthcare sector. The early evidence suggests that competition has its salutary effects on health insurance market even in the post-ACA world. One study (which I coauthored) finds that premiums on the individual exchanges in 2014 were more than 5 percent higher as a result of the decision by a large national insurer not to participate in federally-facilitated exchanges in that year.<sup>36</sup> Another study estimates that having an additional insurer in a given ratings area results in premium savings of nearly \$500 per individual.<sup>37</sup>

#### *3.2 The Medical Loss Ratio (MLR) regulations do not protect consumers from adverse consequences which may arise as a result of consolidation.*

The ACA enacted sweeping regulatory changes on the commercial insurance industry, including minimum product standards, a requirement that insurers take all comers (“guaranteed issue”), a ban on medical underwriting, and limits on age-based pricing. However, the provision that is most relevant to the subject of insurer consolidation and its consequences concerns Medical Loss Ratios (MLRs). As of 2011, insurers must devote at least 85 (80) percent of premium revenues – net of taxes and licensing fees – to medical claims and quality improvement for their large group (small group/individual) fully-insured lives. Insurers failing to satisfy these requirements in any given state and market segment must refund the amount of the shortfall to their enrollees in the relevant segment.

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Medicaid plans in those states. There are a number of new not-for-profit co-operatives as well, however entry of these organizations was subsidized by the federal government and many are not believed to be financially viable.

<sup>36</sup> Leemore Dafny, Jonathan Gruber, and Christopher Ody, “More Insurers, Lower Premiums: Evidence from Initial Pricing on the Health Exchanges,” *American Journal of Health Economics*, Winter 2015: 53–81.

<sup>37</sup> Michael J. Dickstein, et al., “The Impact of Market Size and Composition on Health Insurance Premiums: Evidence from the First Year of the Affordable Care Act,” *American Economic Review*, 105.5 (2015): 120–25.

Some have argued<sup>38</sup> that these regulations mitigate concerns over potential anticompetitive consequences of consolidation in this sector. I do not find this argument convincing for at least five reasons.

First, more than half of privately-insured enrollees are in self-insured plans, and the minimum MLR regulations do not pertain to these plans.

Second, consumers are concerned with “value” for their health insurance dollar, and the minimum MLR restriction does not substitute for competition to provide value. Suppose there are two insurers competing in a given market segment, and both satisfy the MLR requirement for that segment. These insurers likely compete for enrollees on dimensions other than the share of spending devoted to medical claims and quality improvement activities, for example their product design, provider networks, customer service, and chronic disease management programs. Eliminating the competition (or potential competition) from this market via a merger relaxes or eliminates competition on these dimensions. Why expend effort in, say, developing shared savings programs to improve quality of care and reduce spending when you can still pocket the same margin per insured life?<sup>39</sup> In short, the MLR regulation attempts to cap industry profits, but it does not protect consumers from post-merger harm due to the loss of competition on a variety of relevant dimensions.

Third, for the MLR regulations to impact the usual analysis of consolidation effects, they must “bind”: the statutory floors must be higher than we would otherwise see. For example, if insurers in a given market segment and state generally have MLRs above 90 percent, merging insurers benefiting from an increase in market power might still profitably raise profits and premiums by 5 percent. Although there are no published analyses of the MLR data that pinpoint where the regulations currently bind, a recent study by the non-profit Commonwealth Fund reports the following national MLRs for 2013: 85.9% (individual); 83.6% (small group); 88.6% (large group). These data suggest there may be substantial room for profitable merger-related price increases in the individual market in particular, notwithstanding the minimum MLR requirement.

In addition, because the MLR is calculated at the state and market level, it is conceivable that mergers can enable insurers to offset low MLRs in one geographic area or sub-segment with high MLRs in another. For example, consider an insurer offering plans in a (hypothetical) competitive, urban individual exchange ratings area, where MLRs tend to be on the high side (e.g., 90 percent). This insurer could be an attractive target for another insurer who offers plans

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<sup>38</sup> See, e.g., CNBC, “Aetna, Humana CEOs Talk Antitrust Concerns,” Jul. 6, 2015, available at <http://video.cnbc.com/gallery/?video=3000394309>.

<sup>39</sup> Reductions in the value of insurance provided may reduce the total volume of insurance purchased, and hence provide some constraint on the reduction in value that a profit-maximizing monopolist insurer would impose. However, the demand for health insurance is relatively inelastic, and particularly so in light of the new insurance mandates.

in less-competitive rural markets. Post-merger, the insurer might be able to lower MLRs in these markets and use the “excess” spending in the target’s market to offset these new profits.

Fourth, it may be possible to legally “game” the MLR regulation by effectively labeling profits as medical costs. For example, insurers often have ownership stakes in healthcare facilities and provider organizations. Such insurers could adjust internal transfer payments to these groups to ensure MLR minima are satisfied. Similarly, many insurers engage in quality improvement efforts. It would seem possible to create a separate quality improvement arm and to charge the insurance arm fees that offset profits in excess of the MLR minima. Although these possibilities are speculative, the main point is that regulation is an imperfect substitute for competition in terms of keeping premiums low for consumers.

Fifth, the minimum MLR regulation could be repealed. If we permit transactions that would otherwise be deemed anticompetitive under the belief that the MLR regulation acts as a check on post-merger margin increases, where are we left if a more consolidated insurance industry successfully argues for its repeal? As is well known to the Subcommittee, it is an order of magnitude more difficult to dissolve a consummated merger that proves anticompetitive than to prevent the transaction in the first instance.

### *3.3. Reforms to the healthcare delivery system may give rise to new efficiencies from consolidation, but at present these efficiencies are speculative.*

The recent shift toward paying for value – rather than volume – of healthcare services will require significant changes in how insurers pay providers and how providers deliver and organize care. Some insurers have suggested that mergers will enhance their ability to develop and implement new value-based payment agreements.<sup>40</sup>

This claim embeds at least three possible sources of merger efficiencies (1) there are local economies of scale in implementation of value-based agreements; (2) there are non-local economies of scale in implementation of value-based agreements; (3) some insurers have a unique ability to implement such programs and others cannot replicate or access it without a merger.

Argument (1) implies that an insurer must have sufficient scale in a local market area to warrant the investment in changing practice patterns; if not, much of their investment in doing so will “spill over” and benefit rivals. Indeed, a recent study suggests the much-vaunted BCBS-MA Alternative Quality Contract for commercially-insured lives had a significant impact on

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<sup>40</sup> For example, see Aetna’s press release announcing the acquisition of Humana: “The combination will provide Aetna with an enhanced ability to work with providers and create value-based payment agreements that result in better care to consumers, and spread cutting-edge clinical practices and quality care.” Aetna, “Aetna to Acquire Humana for \$37 Billion, Combined Entity to Drive Consumer-Focused, High-Value Health Care,” Jul. 3, 2015, available at <https://news.aetna.com//news-releases/aetna-to-acquire-humana-for-37-billion-combined-entity-to-drive-consumer-focused-high-value-health-care/>.

traditional fee-for-service Medicare enrollees.<sup>41</sup> BCBS-MA does not share in any savings generated for this population. At the same time, a provider can spread its fixed costs of collaborating with a given insurer across more lives the larger is that insurer. Although these are economically appealing arguments, at the moment they are theoretical. There is no evidence that larger insurers are more likely to implement innovative payment and care management programs. In addition, there is a countervailing force offsetting this heightened incentive to invest in payment and delivery system reform: more dominant insurers in a given insurance market are less concerned with ceding market share.

Argument (2) implies that scale across markets may be helpful in implementing value-based agreements. This might be true, for example, because of the ability to work with national employers to develop such programs. However, there is an opposing force that may also operate. Implementing new payment or care management models across disparate markets can introduce complexity and costs into national systems that are poorly designed for exceptions. For example, in early pilots of bundled payment programs, claims have been pulled for individual patients one-by-one out of claims payment processes. These costs are prohibitive and might lead to less, not more, innovation by payers with a cross-market presence. This reality may explain why concerted delivery system reform efforts have tended to emerge from other sources, such as provider systems (sometimes vertically integrated with insurers) and non-national payers like Massachusetts Blue Cross and Blue Shield.

Argument 3 is a standard claim of merger proponents and subject to all the usual forms of skepticism. Efficiencies must be merger-specific and verifiable if they are to be credited against potential harm arising from diminished competition, and there is still the question of whether benefits will be passed through to consumers in light of that diminished competition. Moreover, any short term gain from avoiding development costs for value-based programs may be offset by a reduction in long-term benefits arising from competition among insurers to develop better versions of these programs.

#### **4. Next steps: How to assess proposed and potential consolidation going forward?**

The Horizontal Merger Guidelines issued jointly by the FTC and DOJ explain how the DOJ will evaluate whether a proposed merger violates Section 7 of the Clayton Act. Some likely analyses include: (1) seeking detailed information on how costs will be trimmed *as a result* of any given transaction, and confirming they cannot be achieved in their absence or through means that are less likely to diminish competition; (2) soliciting input from state regulators and other informed stakeholders to gain an understanding of what mergers have proven beneficial in the past and the

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<sup>41</sup> J. Michael McWilliams, Bruce E. Landon, and Michael E. Chernew, "Changes in Health Care Spending and Quality for Medicare Beneficiaries Associated with a Commercial ACO Contract," *JAMA*, 310.8 (2013): 829–836.

characteristics of these mergers; (3) seeking data on MLRs at a granular level, so as to assess the relationship between prior or proposed mergers and MLRs; (4) seeking information from CMS on how Medicare Advantage (MA) is impacted by market structure (both in and outside of MA); (5) evaluating the impact of mergers on prospective entry, and the role of prospective entrants in disciplining premium growth historically; (6) considering the implications of cross-market overlap on insurance competition. This is but a short list of potential analyses.

As the Subcommittee knows, ascertaining whether a transaction violates competition law is a different matter from ascertaining whether it is in the public interest. For example, a merger that is likely to lead to price increases without offsetting benefits may not violate Section 7 if it cannot be shown that the merger lessens competition in a relevant market. Different stakeholders might also place different weights on the potential losses and gains for various affected parties. Given the significance of the insurance sector to our wallets and to the functioning of our healthcare system, the public deserves better data with which to evaluate these transactions as well as the industry more generally. As a start, I would explore avenues for requiring detailed reporting on insurance enrollment, plan design, premiums, and medical loss ratios at a fine unit of geography (e.g., zip code) and for every possible customer segment. This reporting must include self-insured plans (and specifically, the insurance administration charges associated with such plans), as more than half of the privately-insured are enrolled in these types of plans. With these data in hand, policymakers and regulators will be able to monitor market developments and to intervene, if necessary, based on better and more timely information. And researchers such as myself will, in the future, be able to provide much stronger guidance regarding the likely effects of consolidation.