

**Testimony
of the
American Hospital Association
before the
Subcommittee on Antitrust, Competition Policy and Consumer Rights
of the
Committee on the Judiciary
of the
U.S. Senate**

“Examining Consolidation in the Health Insurance Industry and its Impact on Consumers”

September 22, 2015

I am Rick Pollack, president and CEO of the American Hospital Association (AHA). On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, I thank you for the opportunity to testify.

Both of the recently proposed commercial health insurance deals – Anthem’s acquisition of Cigna and Aetna’s acquisition of Humana – could be a blow to millions of health care consumers, as well as the hospitals, doctors and others who are working to improve quality and efficiency while making care more affordable to patients. The unprecedented level of consolidation these deals threaten could make health insurance more expensive and less accessible for consumers. This applies to health insurance purchased in the commercial market as well as Medicare Advantage (MA) plans. These deals also could further entrench the power of the Blues plans, which currently dominate the market in nearly every state.

Another likely casualty of these deals is the momentum hospitals have established to move the nation’s health care system forward. Despite the commercial insurers’ recent claims that they are fostering innovation, they continue to benefit financially from letting hospitals do most of the hard work of reducing readmissions, improving (rigorously measured) patient quality,



experimenting with accountable care organizations (ACOs) and bundling programs, instituting population health programs and numerous other efforts designed to turn a system predicated on volume to one measured by value. There is no reason to believe that allowing these insurers to become even larger and more immune from competitive forces would alter their incentive to sit mostly on the sidelines and reap the considerable financial rewards of providers' innovation.

Neither of the proposed acquisitions should be permitted to move forward until federal and state antitrust and insurance authorities can offer assurances that they are procompetitive, will not leave consumers with fewer and more expensive options for coverage or diminish insurers' willingness to be innovative partners with providers to move our health care system beyond silos to a continuum of care that is responsive to consumers' needs.

SERIOUS CONCERNS ABOUT HEALTH INSURANCE CONSOLIDATION

The AHA recently shared with the Department of Justice's Antitrust Division (Department) our serious concerns about the recently announced acquisitions; the two letters are attached.¹ These deals would eliminate two of the largest national health insurance companies, leaving just three dominant providers of health insurance, and an even more consolidated health insurance market. Recent American Medical Association (AMA) data on health insurance concentration confirms that consolidation is widespread – 70 percent of health insurance markets are “highly concentrated.”²

Concentration Matters. A recent study³ in *Technology Science* highlighted why this increasing concentration should be of particular concern. It found that the largest issuer in each state not only raised premiums by higher amounts, but also raised premiums on more of their plans than other issuers in the same state.

Anthem's Acquisition of Cigna Threatens to Reduce Competition on a Massive Scale.

The potential harm to consumers from the loss of competition that could result from the Anthem/Cigna transaction is large and durable. Because the two companies generate more than \$100 billion in revenue, even a modest price increase would cost consumers billions of dollars in higher health care costs.⁴

The geographic reach of the transaction would be sweeping. It threatens to reduce competition for commercial health insurance in at least 817 markets across the U.S. that serve 45 million consumers. In each of these markets the transaction would produce a Herfindahl-Hirschman Index (HHI) score of 2,500 or more, which the merger guidelines indicate either raise serious or virtually insurmountable competitive issues.

The parties' attempt to explain away the substantial competition between them by creating artificial “submarkets” (by, we assume, customer category and/or policy type) should be viewed with great skepticism. Typically, when companies go to such lengths, it is to obscure competitive overlaps in a desperate effort to demonstrate that a market is competitive. In fact, both companies acknowledge in their public statements that they compete vigorously for the same

group of customers, including large group customers. Moreover, even if such market stratification were valid and the companies do not actually compete in the regions in which they both actively sell commercial insurance, it would reflect enormously high entry barriers and raise questions about anticompetitive coordination (which also should be investigated) and, of course, underscore the deal's enormous anticompetitive potential.

The durability of the anticompetitive impact is enhanced because of the high barriers to entry in the health insurance market. A former Acting Assistant Attorney General modestly described entry as "difficult," particularly in concentrated markets like those at issue in this transaction. One of the very few new companies to even attempt entry described it as "quite daunting."⁵ Just last week, the *New York Times* reported on the demise of a number of health insurance start-ups, concluding that "the [health insurance] marketplace is proving hostile to newcomers trying to break into the industry dominated by powerfully entrenched businesses."⁶

Claims of offsetting efficiencies cannot ameliorate the competitive harm from this deal. 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.⁷ In addition, neither of the legislated controls on excessive premium hikes – medical loss ratio (MLR) or rate review – are sufficient to prevent Anthem from raising rates to consumers above competitive levels.

The MLR measures how much of the premium dollar goes to pay for medical claims and quality activities instead of administrative costs and marketing. Despite its seeming promise, the MLR will not be effective in controlling premium cost increases because: the MLR requirements apply to fewer than 50 percent of Americans under age 65 with health insurance coverage; the rules for reporting MLRs may mask differences in premium rate increases; and the MLR does not address the level of the premium increase, only the percentage used for claims and quality activities.

Likewise, insurance rate review will not prevent rate hikes. Neither the Department of Health and Human Services nor most states have the power to prevent a rate hike. For example, an article in the August 27 *Wall Street Journal*⁸ reported that officials had "greenlighted" hikes in health insurance rates of more than 36 percent in Tennessee, 25 percent in Kentucky and 23 percent in Idaho.

Another concern is that Anthem's affiliation with the Blue Cross and Blue Shield (Blue) system raises some particular competitive concerns. An August 2015 letter⁹ from Joe R. Whatley, Jr., to the Department described the Blue Cross Blue Shield Association's license agreement that prevents the individual Blue plans from directly competing against one another, and also prevents their non-Blue subsidiaries from competing even slightly vigorously against other Blue companies. The letter stated:

Because Anthem cannot expand its non-Blues business, an evaluation of the effects of its merger with Cigna must include not only those geographic markets in which Cigna competes with Anthem, but also those geographic markets where Cigna competes (or would compete) with any other insurers. In each of those markets ... Cigna can no longer compete for new business in any market unless it

decreases its business by an offsetting amount in another market. The net effect is that Cigna's effectiveness as a competitor ... will be impaired.

The letter may only have partially captured the extensive interconnections between Anthem and the other BlueCard members that appear likely to eliminate competition between Cigna and every Blue plan in every state. In fact, the letter may understate the coordination likely to result between Cigna and the non-Anthem Blues plans.

As a result of the folding of Cigna into the overall Blue system through Anthem's Blues affiliation, this deal may augment the already considerable power of the Blue plan in every state. The AMA data report that Blues plans tend to be the most dominant plan in virtually every state in which they operate. Because of the way in which the Blue system operates, Blues plans nationwide may now be able to control Cigna lives – particularly for BlueCard members, including national employer accounts – as their own when they negotiate with providers for rates, terms and conditions under which coverage is available to consumers. If so, this would give these Blues plans even more market power to block entry into their local markets and to constrict plan design and reimbursement rates by, for example, further narrowing provider networks available to consumers and/or driving down rates for those in the network below competitive levels and causing some to decline to participate in any network. The Blues' control over provider reimbursement would increase their ability to put new plans and those hoping to expand at a competitive disadvantage by depriving providers of the flexibility and options to work effectively with those new insurance competitors.

At a time of rising health insurance premiums, the Department and state Attorneys General should examine closely how this acquisition could increase Blue plan dominance nationwide. Blue Cross dominance has been an issue the Department has been concerned with in previous health insurance consolidations. In a speech by former Assistant Attorney General Christine Varney¹⁰, she noted that local health plan dominance (i.e., Blue plan dominance) creates barriers to entry. And, the department has challenged two Blue plan mergers that would have increased that dominance. Given the size and scope of this deal and the dominance of the Blue plans nationwide, the Department should thoroughly investigate how the addition of Cigna to the Blues' arrangement could further entrench that widespread dominance and decrease competition, reduce the number of participating providers and lead to higher consumer premiums.

While it may have been sufficient in the past, it is unlikely that divestitures, no matter how numerous, could rescue this deal. As we noted in our letter to the Department, in “the 817 at-risk markets, over half of the lives that need to be divested reside across 368 MSAs (metropolitan statistical areas) and rural counties [where there is] no divestiture possibility that is likely to preserve” the benefits of competition. Significantly, it has been reported that the divestitures required for two deals overseen by the Federal Trade Commission (FTC) are floundering. That is significant because the divestitures for both deals were much less numerous than those likely to be required for an Anthem/Cigna combination.¹¹ The report highlighted the problems the antitrust agencies face in trying to turn “smaller firms into large competitors capable of absorbing major divestitures.”

Further, the deal could eliminate an irreplaceable source of competition for national accounts and large regional customers. The FTC recently prevailed in a case where it found a national market despite the parties' claims the market was more segmented and localized.¹² Both Cigna and Anthem serve national accounts (large multi-state employers) and large regional customers. As recently as the first quarter of 2015, Anthem's president and CEO told investors it was "optimistic" about the 2016 outlook for national accounts and had closed on two new large accounts serving several hundred thousand lives.¹³ In its second quarter 2015 earnings call with investors, Anthem's chief financial officer and executive vice president suggested its Blues affiliation was an "instrumental part" of its success with national accounts.¹⁴

Aetna's Acquisition of Humana Could Further Concentrate MA Markets Already Suffering from a Lack of Competitive Alternatives. Nearly 18 million people obtain their health insurance through MA, and that number is growing rapidly: "The total Advantage population is up 7.3 percent from ... this time last year, according to the latest CMS data."¹⁵ More than 2.7 million seniors are enrolled in MA plans operated by these insurers in more than 1,000 markets that would become highly concentrated if Aetna is permitted to acquire Humana (this estimate uses the HHI). The deal would not only eliminate current competition between Aetna and Humana in the MA market, it also would eliminate the possibility of future competition between them. Humana is the second-largest MA insurer with 3.23 million members (an 11.4 percent increase over last year), and Aetna the fourth largest with 1.27 million members.¹⁶ As recently as 2014, Aetna appeared to believe it was capable of growing its MA business substantially without this acquisition.¹⁷

This is particularly concerning as there is almost a complete lack of competition in MA markets, according to an August 2015 report by the Commonwealth Fund¹⁸, which found that 97 percent of MA markets in U.S. counties are "highly concentrated." This confirms the findings of a recent report by the Kaiser Family Foundation¹⁹ that also described MA markets as highly concentrated. That report also noted that, while the MA program has continued to grow in virtually all states, MA plans now provide less financial protection for enrollees and average out-of-pocket expenses have continued to climb; this is not an unexpected development in such highly-concentrated markets.

A somewhat perplexing new report from Avalere²⁰ suggests that both the Commonwealth Fund and Kaiser are wrong. The report claims there is new market entry and growth, as well as diversification in MA markets. These new entrants mainly comprise a Blue plan and 15 provider-owned plans. While provider-owned plans offer seniors an excellent choice in the geographic areas they cover, they cannot begin to replace the loss of competition in more than 1,000 markets in 38 states for the 2.7 million seniors that are at risk because of this transaction. Furthermore, some skepticism should be applied to any characterization of a Blue plan as a new entrant into a health insurance market.

The Department has viewed MA as a separate product market because of its unique characteristics. Both lower out-of-pocket costs and a more extensive benefit design have distinguished it from traditional Medicare. While payments to MA plans have moderated, the financial protection and greater range of benefits offered by MA plans continue to attract seniors in large numbers, despite predictions that lowered payments would have the opposite effect.

The high barriers to market entry and lack of efficiencies present in the Anthem deal are present here as well. The remedy the Department has relied on in previous health insurance deals – a series of MA plan divestitures – is unlikely to be sufficient to remediate the likely competitive harm from this deal. The difficulty of implementing successfully this structural remedy should not be underestimated – a suitable acquirer would need to be identified in 1,083 counties in 38 states serving more than 2.7 million current Aetna and Humana members. Even if it were feasible, which it likely is not, it would be a staggering task to develop, implement and supervise these divestitures in a manner that did not further erode the competitive equilibrium in these markets and harm seniors, as well as the promise of the MA program itself.

WHY HOSPITAL DEALS ARE DIFFERENT

Hospitals’ Realignment. Hospitals have shouldered much of the heavy burden of reshaping the nation’s health care system to meet the laudable goals of improving quality and efficiency and making care more affordable for patients and families. And hospitals have made significant strides toward meeting all of those goals. A July 2015 study, reported in the *Journal of the American Medical Association*, described it as a “medical hat trick.”²¹

In this comprehensive analysis of the hospital trends in the Medicare fee-for-service populations aged 65 years and older, there were marked reductions in all-cause mortality rates, all-cause hospitalization rates, and inpatient expenditures, as well as improvements in outcomes during and after hospitalization.

Unlike the insurance deals, which appear motivated by top-line profits, hospital realignment is a procompetitive response to the major forces reshaping the health care system:

- Widespread recognition, especially among those in the hospital field, of the need to replace a “siloe” health care system with a continuum of care that improves coordination and quality and reduces costs for patients;
- Changes in reimbursement models to reward value and encourage population health;
- Increased capital requirements; and
- Competition that is rapidly changing how services are delivered.

Building a Continuum of Care. Building a continuum demands that providers be more integrated. Integration can take many forms – hospitals, physicians, post-acute care providers and others in the health care chain can integrate clinically or financially, horizontally or vertically, and the relationships can range from loose affiliations to complete mergers – and it is happening across the country. For example, a large teaching hospital in Virginia is partnering with other hospitals in the state to form a regional health care system; a New Orleans health system is partnering with four other hospitals across the state to launch a network to provide patients with access to 25 medical facilities and more than 3,000 physicians; and hospitals in Michigan partnered to create a regional affiliation allowing a critical access hospital’s patients access to the full array of services offered by the larger system. In addition, two prestigious teaching hospitals in California have teamed up with a local acute rehabilitation hospital to

develop a world-class regional center for treating complex rehabilitation cases from around the nation.

Hospitals and patients benefit when a hospital realigns. The most common benefits are improved coordination across the care continuum, increased operational efficiencies, greater access to cash and capital for smaller or financially distressed hospitals, and support for innovation, including payment alternatives that entail financial risk. For financially struggling hospitals, finding a partner can make all the difference. For example:

- A health system in Ohio acquired a small, community hospital in bankruptcy with closure impending; it expanded access to care in the rural area, increased technological efficiencies and saved 250 community jobs.
- An acquisition by a nearby hospital system of a hospital that was struggling financially led to it being transformed into a much-needed regional children's hospital, which provided improved access and services for area children.

Regulatory Barriers Persist for Integration. While innovative partnerships and integrative arrangements abound throughout the country, permanent arrangements, such as mergers, offer the most protection from a staggering array of outdated regulatory barriers that make integration risky when Medicare or Medicaid patients are involved. Despite the AHA having identified the five main barriers to clinical integration more than 10 years ago, to date, only one regulatory barrier has been addressed. The following barriers remain:

- Lack of antitrust guidance on clinical integration (current guidance applies only to arrangements that are part of ACOs);
- Restrictions on arrangements that base payments on achievements in quality and efficiency instead of just hours worked (Stark Law);
- Restrictions on financial incentives to physicians that could be construed as influencing care provided, even if the goal of the incentive is to adopt proven protocols and procedures to improve care (Anti-kickback law); and
- Uncertainty about how the Internal Revenue Service will view payments from tax-exempt hospitals to non-tax exempt physicians working together in clinically integrated arrangements.

It is notable that all these barriers to clinical integration had to be addressed to allow the ACO program to move forward. Yet, the federal agencies responsible for administering these laws and regulations have yet to modernize them, with one limited exception, to support even more progress toward building a continuum of care through innovative arrangements like those described above.

MOVING TO A VALUE-BASED REIMBURSEMENT SYSTEM

Increasingly, reimbursement models are being recast to compensate providers based on outcomes, not the volume of services provided. The outcomes being rewarded include keeping

patients well (population health) and providing high-quality services when patients are in the hospital.

Many hospitals, health systems and payers are adopting delivery system reforms with the goal of better aligning provider incentives to achieve higher-quality care at lower costs. These reforms include forming ACOs, bundling services and payments for episodes of care, developing new incentives to engage physicians in improving quality and efficiency, and testing payment alternatives for vulnerable populations. The Centers for Medicare & Medicaid Services (CMS) recently announced a goal of moving 30 percent of Medicare payments to alternative models of reimbursement that reward value by 2016 and to 50 percent of payments by 2018. In its announcement, CMS recognized that achieving these goals would require hospitals to “make fundamental changes in their day-to-day operations that improve the quality and reduce the cost of health care.”

Hospitals have supported these efforts and often take the lead in testing and improving them. In addition, hospitals are collaborating with and learning from each other in order to improve the quality of care they deliver to patients. For example, the Health Research & Educational Trust (HRET), an AHA affiliate, was awarded a contract by CMS to support the Partnership for Patients campaign, a three-year, public-private partnership designed to improve the quality, safety and affordability of health care for all Americans. The AHA/HRET Hospital Engagement Network project helped hospitals adopt new practices with the goal of improving patient care and reducing readmissions by 20 percent. The project, which included a network of nearly 1,500 hospitals across 31 states, focused on several areas of impact and produced cost savings of \$988 million through improved care. Some additional highlights include: a 61 percent reduction in early elective deliveries across 800 birthing hospitals; a 48 percent reduction in venous thromboembolism (blood clot in a vein) across 900 hospitals; and a 54 percent reduction in pressure ulcers across 1,200 hospitals.

Meanwhile, many hospitals report that it has been difficult to work with commercial insurers in moving to new payment models. We recently surveyed members of AHA’s nine regional policy boards, which represent hundreds of hospitals around the nation, about their experience working with commercial insurers on new payment models. About 80 percent reported it was a challenge to work with insurers on new payment models, and more than 40 percent described it as a major challenge.

INCREASED CAPITAL REQUIREMENTS

The fundamental restructuring that CMS anticipates in response to its alternative reimbursement models will undoubtedly come with a high cost that will be particularly difficult to bear for small and stand-alone hospitals. Already, the field is under serious financial pressure from the need for capital expenditures, particularly those for health information technology (IT) and electronic health records (EHRs). In fact, the AHA estimates that hospitals collectively spent \$47 billion on IT, including EHRs, each and every year between 2010 and 2013.

EHRs are essential to improving care and, consequently, succeeding in value-based reimbursement models. Every hospital is expected to meet a constantly evolving set of standards for having and using EHRs for their patients. And a portion of Medicare and Medicaid reimbursement is conditioned on EHR adoption and use. Estimates are that EHRs will cost a hospital between \$20 and \$200 million depending on their size. For smaller, rural and stand-alone hospitals, these costs can be ruinous without a partner to absorb some of the cost and provide the necessary technical expertise.

For many hospitals, the credit markets are already difficult to access. The most recent FitchRating report confirms this; starting in 2011, the profitability “metrics” for the lowest-rated hospitals have declined.²² The lowest-rated hospitals tend to be smaller or stand-alone. The debt burden for the lowest-rated hospitals also has continued to grow, and the hospitals’ operating margins are razor thin. For these hospitals, accessing the credit markets for capital improvements, including technology, will be difficult, if at all possible. Without a partner, these hospitals will continue to decline until they are forced to close their doors, with potentially devastating repercussions for the communities they serve.

NEW COMPETITION FOR HOSPITAL SERVICES

Rapid changes in the health care market are providing consumers with an increased array of options for their health care, including services that hospitals provide.

CVS, Walgreens and Wal-Mart, among others, are changing where consumers go for their health care needs. The retailers offer an array of health care services, including primary care, immunizations, blood pressure monitoring and routine blood tests, all of which were formerly available only in a doctor’s office or hospital outpatient clinic or emergency room. Meanwhile, many of the retailers plan to provide even more sophisticated care and services at their thousands of convenient locations. These developments challenge hospitals to become more integrated with physicians and other providers so that they too can offer convenient and more affordable care that is attractive to patients.

In addition, telehealth promises to revolutionize how an incredible array of health care services are provided to consumers and to change the competitive landscape entirely. Telehealth is already delivering services as different as dermatology and mental health to patients across town and across the country. A hospital in Arlington, Va., has an arrangement with the Mayo Clinic, which is based in Rochester, Minn., that allows its patients access to Mayo’s expertise without leaving the neighborhood. In addition, a hospital system in California was able to cover its need for physician intensivists at one of its satellite facilities using mobile telehealth devices instead of hiring new doctors, with positive clinical and patient satisfaction outcomes. Increasingly, patients are able to consult doctors using their computers, laptops and smartphones, and this is becoming a more common expectation of patients when they seek care. For their part, insurers too are increasingly relying on telehealth to reduce costs and meet network adequacy requirements. All of this changes the competitive landscape for hospitals. Now, competitors for even specialized services do not have to be in the same neighborhood, city or state to connect with patients who might otherwise have sought care at their local hospital.

The rapid growth of telehealth illustrates how quickly the competitive landscape can change for hospitals and the importance of having adequate financial resources and access to capital. Without those resources, hospitals cannot keep up with the demands of new technology or the opportunities they present.

CONCLUSION

Consumers and the entire health care system are threatened by the potential consequences of the unprecedented consolidation that would result from Anthem's acquisition of Cigna and Aetna's acquisition of Humana. These health insurance deals, which would affect at least one form of health insurance in every state, could mean fewer choices for consumers for commercial insurance and MA plans, narrower networks of providers in what few choices remain and higher prices for premiums or more out-of-pocket costs. The deals also could diminish insurers' willingness to be innovative partners with providers, as well as jeopardize the momentum hospitals have led to improve quality and efficiency while making care more affordable for patients and families.

Some have compared the insurance deals to those in the telecommunications arena because of their size and the enduring ability to contort the market and harm consumers. The Department was ready to challenge the telecommunications deals, and it also should be ready to challenge the insurance deals, if, as we expect, its intensive investigation confirms that these transactions threaten the growth and vitality of our health care system and the health and welfare of consumers across the nation.

¹ www.aha.org/letters

² Competition in Health Insurance A comprehensive study of U.S. markets, American Medical Association, 2015 Update, https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product_id=prod2680007&navAction=push#usage-tab.

³ Wang E, Gee G. Larger Issuers, Larger Premium Increases: Health insurance issuer competition post-ACA. *Technology Science*. 2015081104. August 11, 2015. <http://techscience.org/a/2015081104>.

⁴ AHA letter to the Honorable William Baer, August 5, 2015.

⁵ This \$1.5 billion Startup is Making Health Insurance Suck Less, *Wired*, March, 20, 2015 <http://www.wired.com/2015/04/oscar-funding/>.

⁶ Tough Going for Co-Ops, *New York Times*, September 15, 2015.

⁷ Testimony of Professor Thomas L. Greaney, Before the House of Representatives Subcommittee on Regulatory Reform, Commercial and Antitrust Law, September 10, 2015.

⁸ Insurers Win Big Health-Rate Increases, *Wall Street Journal*, August 27, 2015. <http://www.wsj.com/articles/insurers-win-big-health-rate-increases-1440628848>.

⁹ Joe R. Whatley, Jr., letter to the Honorable William Baer, August 13, 2015.

¹⁰ Remarks of Christine Varney, then Assistant Attorney General of the DOJ's Antitrust Division, at a joint American Bar Association/American Health Lawyers Association Antitrust in Healthcare Conference, May 24, 2010, available at <http://www.justice.gov/atr/speech/antitrust-andhealthcare>

¹¹ Reporting on divestitures ordered in the car rental and grocery store industries. Divestitures required were 58 on-airport locations and a line of business for the Hertz deal and 168 supermarkets in 130 locations for Albertsons. <http://pipeline.thedeal.com/tdd/ViewArticle.dl?s=dd&id=13291361&cmpid=em:DA091715#ixzz3m1SYWNdc>

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- ¹² *FTC v. Sysco Corp*, (D.D.C.) June 23, 2015 at <https://www.ftc.gov/system/files/documents/cases/150623syscomemo.pdf>
- ¹³ Anthem Quarter 1 Earnings Call with Investors, April 29, 2015, <http://www.thestreet.com/story/13131183/1/anthem-antm-earnings-report-q1-2015-conference-call-transcript.html>.
- ¹⁴ Anthem Quarter 2 Earnings Call with Investors, July 29, 2015, <http://phx.corporate-ir.net/External.File?item=UGFyZW50SUQ9NTg4NjExfENoaWxkSUQ9Mjk2ODg1fFR5cGU9MQ==&t=1>.
- ¹⁵ Medicare Advantage membership nearly 18 million ahead of annual enrollment, Modern Healthcare, September 17, 2015 (Modern).
- ¹⁶ Modern.
- ¹⁷ AHA letter to the Honorable William Baer and Secretary Burwell, September 1, 2015 (see chart page 16).
- ¹⁸ Brian Biles, Giselle Casillas, and Stuart Guterman, Competition Among Medicare’s Private Health Plans: Does It Really Exist?, The Commonwealth Fund August 2015, www.commonwealthfund.org/publications/issue-briefs/2015/aug/competition-medicare-private-plans-does-it-exist.
- ¹⁹ Gretchen Jacobson, Anthony Damico and Marsha Gold, Kaiser Family Foundation Issue Brief, Medicare Advantage 2015 Spotlight: Enrollment Market Update, June 30, 2015, <http://kff.org/medicare/issuebrief/medicare-advantage-2015-spotlight-enrollment-market-update/>.
- ²⁰ New Market Entrants: Growth and Diversification in U.S. Health Insurance, Avalere, September 2015.
- ²¹ ‘Jaw-dropping’: Medicare deaths, hospitals AND costs reduced, USA Today, July 28, 2015. Reporting on “Mortality, Hospitalizations, and Expenditures for the Medicare Population Aged 65 Years and Older, 1999-2013”, Krumholz, Nuti, Downing, Normand & Wang, JAMA, July 28, 2015, Vol. 312, No. 4.
- ²² FitchRatings, 2015 Medium Ratios for Nonprofit Hospitals and Health Systems, Special Report, August 10, 2015.



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By Email and Courier

September 1, 2015

The Honorable William Baer
Assistant Attorney General
United States Department of Justice Antitrust Division
950 Pennsylvania Avenue, N.W.
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The Honorable Sylvia Burwell
Secretary
Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Assistant Attorney General Baer and Secretary Burwell:

I'm writing on behalf of nearly 5,000 member hospitals, health systems and other health care organizations, and 43,000 individual members of the American Hospital Association (AHA) regarding the proposed acquisition involving two of the five major commercial health insurance companies in the United States: Aetna's proposed acquisition of Humana. We previously wrote to the Department of Justice's Antitrust Division (Department) on August 5, 2015, about the proposed acquisition of Cigna by Anthem. That letter is attached.

Our concerns about the proposed Aetna/Humana deal are similar in many respects. Both have the very real potential to reduce competition substantially, increase the cost of premiums, and diminish the insurers' willingness to be innovative partners with providers and consumers in transforming health care. Viewed in tandem the two deals would reduce the number of major health insurers from five to three and adversely impact millions of consumers.

The proposed Aetna/Humana deal raises particular concerns about an adverse impact on the Medicare Advantage program. More than 2.7 million seniors are enrolled in Medicare advantage plans operated by the companies in more than 1,000 markets that would become highly concentrated. In previous investigations the Department has viewed Medicare Advantage markets as distinct from traditional Medicare, "[d]ue in large part to the lower out-of-pocket



costs and richer benefits that many Medicare Advantage plans offer seniors over traditional Medicare.” *United States v. UnitedHealth Group Inc. and Sierra Health Services, Inc.*¹

Yet, some of the benefits Medicare Advantage plans offer may be eroding. This erosion is not the result of legislative changes to the program in the Affordable Care Act but is due in significant part to the lack of robust competition among Medicare Advantage plans. A recent Kaiser Family Foundation report described Medicare Advantage markets as “highly concentrated among large firms.” It also cautioned that while enrollment in the Medicare Advantage program has continued to grow and increase in virtually all states, Medicare Advantage plans “provide less financial protection to Medicare enrollees than they have in the past ... [and] [a]verage out-of-pocket spending limits have continued to rise.”² The almost complete absence of competition in Medicare Advantage markets was highlighted in a report just issued by the Commonwealth Fund. The report studied the state of competition in every Medicare Advantage market and found “97 percent of markets in U.S. counties are highly concentrated and therefore lacking in significant Medicare Advantage plan competition.”³

The substantial barriers to entry in the health insurance sector make it extraordinarily unlikely that existing firms could replicate the size and scope of the insurers involved in this proposed transaction. This strongly suggests that the acquisition likely would serve only to exacerbate problematic coverage and cost trends as well as produce other adverse impacts on access and innovation. Significantly, it appears doubtful that divestitures alone would remedy the loss of competition threatened by this acquisition.

The attached analysis details the competitive issues that the Department will consider as it reviews this deal and the precedents that suggest it is, and should be, at risk. We understand that the Department will work closely with the Department of Health and Human Services (HHS) in understanding fully the potential anticompetitive impacts of the deal on the Medicare Advantage program. We look forward to working with both agencies throughout the course of this investigation. To that end, we will be contacting representatives of both agencies to request meetings with top officials and staff to discuss more fully our concerns and ways in which we can be of assistance.

For more information, you can contact me directly at mhatton@aha.org or (202) 626-2336.

¹ Competitive Impact Statement, *United States v. UnitedHealth Group Inc. and Sierra Health Services, Inc.*, No. 08-cv-322 (D.D.C. Feb. 25, 2008), available at www.justice.gov/atr/case/us-v-unitedhealth-group-inc-and-sierra-health-services-inc.

² Gretchen Jacobson, Anthony Damico and Marsha Gold, Kaiser Family Foundation Issue Brief, *Medicare Advantage 2015 Spotlight: Enrollment Market Update*, (June 30, 2015), available at <http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/>.

³ Brian Biles, Giselle Casillas, and Stuart Guterman, *Competition Among Medicare’s Private Health Plans: Does It Really Exist?*, The Commonwealth Fund (August 25, 2014), available at www.commonwealthfund.org/publications/issue-briefs/2015/aug/competition-medicare-private-plans-does-it-exist.

The Honorable William Baer
The Honorable Sylvia Burwell
September 1, 2015
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Sincerely,

/s/

Melinda Reid Hatton
Senior Vice President & General Counsel

cc: Andy Slavitt, Acting Administrator for the Centers for Medicare & Medicaid Services

Attachment

Detailed Analysis of the Aetna/Humana Merger Submitted by the American Hospital Association

On behalf of the nearly 5,000 members of the American Hospital Association, we urge that the Department of Justice's Antitrust Division (Department) thoroughly investigate Aetna's proposed \$37 billion acquisition of Humana.⁴ The transaction is likely to lessen competition substantially in violation of Section 7 of the Clayton Act.⁵ The harm the transaction threatens to consumers—and particularly to senior citizens and other vulnerable populations who depend on Medicare Advantage programs for their health care—is large and durable. Almost one in three Medicare beneficiaries, amounting to 16.8 million people, obtain their health care through a Medicare Advantage plan.⁶ Yet, as the Kaiser Family Foundation observed in a recent report, “Medicare Advantage enrollment . . . tends to be highly concentrated among a small number of firms.”⁷ Humana and Aetna are leaders in this critical market. Their merger will increase already high levels of concentration even further, making the combined company the largest Medicare Advantage insurer in the country with one million more members than the current largest insurer, UnitedHealthcare.⁸ The resulting loss of competition will harm seniors by making it considerably more difficult for them to obtain affordable, comprehensive health care coverage.

1. The Parties

A. Aetna

Aetna is one of the nation's largest health insurance companies, with \$58 billion in revenues in 2014.⁹ The company is financially strong, and boasted of “strong growth” in its “core businesses” in 2014, when it set records in both operating revenues and operating earnings.¹⁰

⁴ Aetna news release, available at <https://news.aetna.com/aetna-to-acquire-humana/>.

⁵ 15 U.S.C. § 18.

⁶ 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/> (hereafter “KFF June 2015 Issue Brief”).

⁷ *Id.* at 13. In fact, in a report released just days ago, The Commonwealth Fund found that 2,852 of the 2,933 counties studied (97 percent) have “highly concentrated” MA markets, using the definition for that term set forth in the Department of Justice's merger guidelines. Brian Biles, Giselle Casillas, and Stuart Guterman, *Competition Among Medicare's Private Health Plans: Does It Really Exist?*, The Commonwealth Fund (August 25, 2014), available at www.commonwealthfund.org/publications/issue-briefs/2015/aug/competition-medicare-private-plans-does-it-exist.

⁸ KFF June 2015 Issue Brief at Fig. 14; see also Anna Wilde Mathews, Liz Hoffman, Dana Mattioli, *With Merger Deal, Aetna, Humana Get Ahead of the Pack*, Wall Street Journal (July 6, 2015) (the combined companies “would have about a million more members in Medicare Advantage . . . than their next-closest competitor, UnitedHealth”), available at www.wsj.com/articles/with-merger-deal-aetna-humana-get-ahead-of-the-pack-1436143581.

⁹ Aetna Annual Report (2014) at 2, available at <http://phx.corporate-ir.net/External.File?item=UGFyZW50SUQ9NTc0OTUyYfENoaWxkSUQ9Mjc4NDQyYfFR5cGU9MQ==&t=1>. \$55 billion are derived from Aetna's health care businesses.

¹⁰ *Id.*

Aetna offers a full range of health care insurance products. In 2014, 23.5 million people received medical coverage through Aetna. These included people for whom Aetna provided medical insurance and those who received coverage through self-insured employers that contracted with Aetna for administrative services.¹¹ Aetna added approximately 1.4 million medical members between 2013 and 2014, thereby growing its membership at a rate of about 6 percent.¹²

“One of the keys” to Aetna’s results in 2014, its chairman reported in his annual letter to shareholders, “was the strength of our Government business, which now represents over 40 percent of Aetna’s total health premiums.”¹³ Premiums in the company’s government business grew dramatically in 2014, “primarily driven by Medicare Advantage membership growth of almost 18 percent” and by strong Medicare Supplement growth as well.¹⁴ The company has Medicare Advantage enrollees in every state in the country, other than North Dakota.

B. Humana

Humana also is one of the largest health insurers in the U.S., with more than \$48 billion in total revenues in 2014.¹⁵ It has almost 14 million medical members.¹⁶

The company has long been a leader in Medicare products. The company offers at least one Medicare product in every state.¹⁷ Humana today is the second largest Medicare Advantage insurer in the U.S., just behind UnitedHealthcare.¹⁸ Fully 54 percent of Humana’s revenues derive from Medicare Advantage products.¹⁹ Total Medicare Advantage membership increased 18 percent between 2013 and 2014.²⁰ Humana claims that its strength in Medicare Advantage provides it “with greater ability to expand our network of PPO and HMO providers” and so it is well positioned to maintain and expand its strength in Medicare Advantage markets.²¹

2. Application of the Antitrust Laws to this Transaction

As noted in the analysis of the Anthem/Cigna transaction we provided on August 5, 2015,²² health insurance competition is vital if the promise of increased access to affordable health insurance coverage, embodied in the Affordable Care Act (ACA), is to be realized. The

¹¹ Aetna Annual Report (2014) at 10.

¹² *Id.*

¹³ Mark T. Bertolini, Chairman and CEO, Letter to shareholders (April 2015), available at <http://phx.corporate-ir.net/External.File?item=UGFyZW50SUQ9NTc0OTUyfENoaWxkSUQ9Mjc4NDQyfFR5cGU9MQ==&t=1>.

¹⁴ *Id.*

¹⁵ Humana 10-K for YE 2014 (attached to 2014 Annual Report), at 81, available at <http://phx.corporate-ir.net/External.File?item=UGFyZW50SUQ9NTcyNjgzfENoaWxkSUQ9Mjc0NTQ3fFR5cGU9MQ==&t=1>.

¹⁶ *Id.* at 12; see also *id.* at 38.

¹⁷ *Id.* at 5.

¹⁸ KFF June 2015 Issue Brief at Fig. 14.

¹⁹ Humana 10-K for YE 2014 (attached to 2014 Annual Report), *supra*, at 5.

²⁰ 2014 Annual Report, *supra*, at 3.

²¹ Humana 10-K for YE 2014 (attached to 2014 Annual Report), *supra*, at 5.

²² Letter from Melinda Reid Hatton to William Baer, at 7 (August 5, 2015), available at <http://www.aha.org/advocacy-issues/letter/2015/150805-let-acquisitions.pdf>.

Department, which has reviewed carefully every health insurance merger in recent years, has been adamant that competition must be preserved among insurers. The Acting Assistant Attorney General in charge of the Antitrust Division remarked three years ago that “the division has brought a number of enforcement actions against health insurance mergers” as part of its “commitment to carefully review mergers in the health insurance industry and challenge those mergers that may substantially lessen competition in properly defined markets.”²³

To fulfill this commitment to protect competition in health insurance markets, the Department has filed many actions against insurers seeking to merge or otherwise act anticompetitively.²⁴ Significantly, in two of the cases filed over the last several years involving mergers of health insurers, the Department recognized the particular importance of preserving competition in the Medicare Advantage market:

- In 2008, after UnitedHealth proposed to acquire Sierra Health Services, the Department sued to protect competition in the provision of Medicare Advantage plans in Las Vegas.²⁵ The Department noted Congress created Medicare Advantage “as a private market alternative” to the traditional Medicare program. “In establishing the Medicare Advantage program, Congress intended that vigorous competition among private Medicare Advantage insurers would lead insurers to offer seniors richer and more affordable benefits than traditional Medicare, provide a wider array of health-insurance choices, and be more responsive to the demands of seniors.” The Department alleged the proposed merger would end all competition between UnitedHealth and Sierra, thereby “eliminating the pressure that these close competitors place on each other to maintain attractive benefits, lower prices, and high-quality health care.”²⁶ The Department settled the complaint through entry of a consent decree that required the merged company to preserve competition in the market for Medicare Advantage in Las Vegas by divesting individual Medicare Advantage lives in the two counties encompassing that city.²⁷

²³ 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* (Mar. 19, 2012), at 4, 6, available at www.justice.gov/atr/speech/competition-and-health-care-prescription-high-quality-affordable-care. Less than two years earlier, Christine Varney, then Assistant Attorney General of the DOJ’s Antitrust Division, made a similar point in remarks given to a joint American Bar Association/American Health Lawyers Association Antitrust in Healthcare Conference, (May 24, 2010), available at <http://www.justice.gov/atr/speech/antitrust-and-healthcare>.

²⁴ Several cases brought by the Department to protect competition in health insurance markets are discussed in the Pozen speech, *supra* n.8. Others are identified in the AHA’s August 5 letter, *supra* n.6, at 7 n.19.

²⁵ Complaint, *United States v. UnitedHealth Group Inc. and Sierra Health Services, Inc.*, No. 08-cv-322 (D.D.C. Feb. 25, 2008), available at www.justice.gov/atr/case/us-v-unitedhealth-group-inc-and-sierra-health-services-inc.

²⁶ *Id.* at ¶ 3.

²⁷ Final Judgment *United States v. UnitedHealth Group Inc. and Sierra Health Services, Inc.*, No. 08-cv-322 (D.D.C. Sept. 24, 2008), available at www.justice.gov/atr/case/us-v-unitedhealth-group-inc-and-sierra-health-services-inc; see also Competitive Impact Statement (Feb. 25, 2008) (available at same website).

- In 2012, the Department sued to block the proposed acquisition by Humana Inc. of Arcadian Management Services, Inc.²⁸ The Department charged the proposed acquisition would “significantly lessen competition among Medicare Advantage plans and eliminate substantial head-to-head competition between Humana and Arcadian in the provision of such plans” in 45 relevant geographic markets.²⁹ The competition between the two companies, the Department noted, “has significantly benefited thousands of seniors” who look to Medicare Advantage plans to obtain “greater benefits than those available under traditional Medicare.”³⁰ The Department resolved the complaint when the merging companies agreed to divest individual Medicare Advantage business in each of the relevant geographic markets.³¹ Without the divestitures, the Department warned, “[t]he loss of competition from the acquisition likely would result in higher premiums and reduced benefits and services in these markets.”³²

A. Relevant Product Market

1. The Medicare Advantage Program

a. Medicare Advantage Before The Passage Of The ACA

The Department demonstrated a thorough understanding of the Medicare Advantage market in the complaints and competitive impact statements filed in the UnitedHealth/Sierra and Humana/Arcadian transactions.³³ As the Department noted there, in the traditional, government-operated Medicare program, a beneficiary generally receives coverage for hospital services under Part A of the program for free if he or she worked and paid Medicare taxes. A beneficiary may elect to receive coverage for physician and other outpatient services under Part B upon payment of a premium. To receive prescription drug coverage a beneficiary enrolled in traditional Medicare program must enroll in a Medicare prescription drug plan under Medicare’s Part D for an additional monthly premium.

²⁸ Complaint, *United States v. Humana Inc. and Arcadian Management Services, Inc.*, No. 12-cv-464 (D.D.C., March 27, 2012), available at www.justice.gov/atr/case/us-v-humana-inc-and-arcadian-management-services-inc.

²⁹ *Id.* at ¶ 4.

³⁰ *Id.*

³¹ Final Judgment, *United States v. Humana Inc. and Arcadian Management Services, Inc.*, No. 12-cv-464 (D.D.C., Sept. 21, 2012), available at www.justice.gov/atr/case/us-v-humana-inc-and-arcadian-management-services-inc; see also Competitive Impact Statement (March 27, 2012) (available at same website).

³² Competitive Impact Statement, *United States v. Humana, supra*, at 1.

³³ *United States v. UnitedHealth Group Inc. and Sierra Health Services, Inc.*, No. 08-cv-322, available at www.justice.gov/atr/case/us-v-unitedhealth-group-inc-and-sierra-health-services-inc; *United States v. Humana Inc. and Arcadian Management Services, Inc.*, No. 12-cv-464, available at www.justice.gov/atr/case/us-v-humana-inc-and-arcadian-management-services-inc.

The Part B premium for most beneficiaries in 2015 is \$104.90 per month.³⁴ The cost of a stand-alone Part D plan varies widely, but in 2015 averages about \$38.80 per month.³⁵ Assuming a beneficiary obtains covered medical services, he or she may incur substantial additional costs:

- The deductible for hospitalization under Medicare Part A is \$1,260 in 2015. If a hospital stay lasts longer than 60 days, prescribed coinsurance amounts must be paid by the beneficiary.³⁶
- The deductible for Medicare Part B this year is \$147.³⁷
 - Once beneficiaries meet the deductible, they typically must pay 20 percent of the Medicare allowed amounts.
- There is *no* annual limit on out-of-pocket costs incurred under either Part A or Part B. “If beneficiaries want to limit potentially catastrophic out-of-pocket costs, they need to purchase a separate Medicare Supplement plan.”³⁸

Medicare Advantage plans must provide all Medicare-covered services (Parts A and B). Beneficiaries pay a premium established by the plan and are responsible as well for the Part B premium. From the point of view of beneficiaries, there are many differences between Medicare Advantage and traditional Medicare. Some of the critically important differences include:

- ***Additional benefits.*** Medicare Advantage plans may (and usually do) provide benefits not provided by Medicare. These additional services often include dental and vision benefits, and may include hearing and health and wellness programs.³⁹
- ***Prescription drug coverage.*** The overwhelming majority of Medicare Advantage enrollees (88 percent) participate in a plan (an MA-PD) that includes a prescription drug benefit.⁴⁰

³⁴ Medicare.gov, *Medicare 2015 costs at a glance*, available at www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html. Beneficiaries with modified adjusted gross incomes above \$85,000 for individuals and \$170,000 for joint filers are charged higher amounts. *Id.*

³⁵ See Jack Hoadley et al., *Medicare Part D: A First Look at Plan Offerings in 2015*, Kaiser Family Foundation (Oct. 10, 2014), available at <http://kff.org/report-section/medicare-part-d-a-first-look-at-plan-offerings-in-2015-key-findings/>; see also Medicare.gov, *Monthly Premium for Drug Plans*, www.medicare.gov/part-d/costs/part-d-costs.html.

³⁶ These can be substantial: \$315 per day for days 61-90 and \$630 after that for a prescribed number of “lifetime reserve days” after which the beneficiary must pay the entire amount incurred. *Medicare 2015 costs at a glance*, *supra*.

³⁷ *Medicare 2015 costs at a glance*, *supra*.

³⁸ Competitive Impact Statement, *United States v. UnitedHealth*, *supra*, at 5.

³⁹ See generally Medicare.gov, *Medicare Advantage plans cover all Medicare services*, available at www.medicare.gov/what-medicare-covers/medicare-health-plans/medicare-advantage-plans-cover-all-medicare-services.html.

⁴⁰ KFF June 2015 Issue Brief at 7.

- The standard Part D benefit design has a \$320 deductible and requires 25 percent coinsurance up to \$2,960 in drug costs.⁴¹ At that expenditure level, a “donut hole” opens: beneficiaries are responsible for 45 percent of the cost of the drug (in 2015) until their out-of-pocket hits \$4,700, after which they pay 5 percent of their drug costs.⁴²
- Enrollees in MA-PDs generally have better coverage than do those who must buy a Part D plan directly: fully 58 percent of MA-PD enrollees participate in plans that have *no* Part D deductible.⁴³ Such no-deductible drug plans are more common in Medicare Advantage than in Part D plans available to traditional Medicare enrollees.⁴⁴ And, almost half (45 percent) of MA-PD enrollees are in plans that close some of the “donut hole” in Part D’s drug coverage.⁴⁵
- **Premium cost.** The average enrollee in a MA-PD plan in 2015 pays a monthly plan premium of about \$38.⁴⁶ Medicare Advantage plans may use savings to reduce—sometimes to zero—the premiums they charge for coverage. In 2015, 78 percent of all MA-PD enrollees had a choice of at least one plan that charged nothing for Medicare Advantage coverage, leaving enrollees responsible only for their Part B premium.⁴⁷ Almost one-half of all MA-PD enrollees participate in these “zero-premium” plans.⁴⁸ Some plans go even further, and use their savings to reduce the Part B premium.⁴⁹
- **Out-of-pocket limits.** Medicare Advantage plans must limit out-of-pocket expenditures for Part A and Part B services.⁵⁰ The out-of-pocket limit in 2015 can be no greater than \$6,700 per Medicare Advantage enrollee annually. In fact, the average out-of-pocket limit in 2015 is less: \$5,041 per enrollee.⁵¹

Medicare Advantage plans are sold predominantly to individuals and less frequently to groups.⁵² Almost 64 percent of Medicare Advantage enrollees participate in a health maintenance

⁴¹ KFF June 2015 Issue Brief at 11.

⁴² *Id.*

⁴³ *Id.*

⁴⁴ Gretchen Jacobson, Anthony Damico, Tricia Neuman, and Marsha Gold, Kaiser Family Foundation Issue Brief, *Medicare Advantage 2015 Data Spotlight: Overview of Plan Changes*, (Dec. 10, 2014), at 11, available at <http://files.kff.org/attachment/data-spotlight-medicare-advantage-2015-data-spotlight-overview-of-plan-changes>

⁴⁵ KFF June 2015 Issue Brief at 11.

⁴⁶ KFF June 2015 Issue Brief at 8.

⁴⁷ *Id.* at 8.

⁴⁸ *Id.*

⁴⁹ Medicare Payment Advisory Commission (“MedPAC”), *Report to the Congress: Medicare Payment Policy*, (March 2015), Ch. 13, available at [www.medpac.gov/documents/reports/chapter-13-the-medicare-advantage-program-status-report-\(march-2015-report\).pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/chapter-13-the-medicare-advantage-program-status-report-(march-2015-report).pdf?sfvrsn=0).

⁵⁰ *Id.*

⁵¹ KFF June 2015 Issue Brief at 10.

⁵² According to MedPAC, as of February 2015, about 3 million enrollees were in employer group plans, or about 19 percent of all Medicare Advantage enrollees. About 2 million were in special needs plans. MedPAC, *A Data Book*,

organization (HMO).⁵³ Preferred provider organizations (PPOs) provide coverage to 31 percent of the enrollees. Just 5 percent of all Medicare Advantage enrollees obtain services through private fee-for-service plans,⁵⁴ and that proportion has “fallen precipitously” since 2008.⁵⁵ Consistent with the usual way in which HMOs and PPOs operate, enrollees in these plans usually obtain care from a more limited network than offered by traditional Medicare, and these plans (and in particular, the HMOs) typically manage the care provided.⁵⁶

b. Changes To The Medicare Advantage Program Made By The ACA

An insurer wishing to offer a Medicare Advantage plan in a county must submit a bid to the Centers for Medicare & Medicaid Services (CMS). The bid covers the insurer’s projected cost to provide required Medicare benefits under Part A and Part B to a beneficiary. CMS compares the bid (plus an amount for profit) to a local payment benchmark intended to reflect, in part, the cost of providing care through the traditional Medicare system.⁵⁷ Through 2011, Medicare retained 25 percent of the amount (if any) by which the benchmark exceeded the bid.⁵⁸ The balance (75 percent) was rebated to the bidder and used to provide supplemental benefits or lower premiums (including Part B premiums).⁵⁹ The Department has recognized that this structure “encourages insurers to compete against each other to attract Medicare beneficiaries by providing low prices and more benefits.”⁶⁰

Before the ACA, Medicare Advantage plans were being paid, on average, 114 percent of Medicare fee-for-service costs per enrollee.⁶¹ The ACA seeks to change this structure so as to reduce, if not entirely eliminate, the payment difference per enrollee. The ACA does this in two ways: first, it gradually reduces the benchmarks. Second, it reduces the amount rebated from 75 percent of the difference between a bid and the benchmark to an amount ranging from 50 percent to 70 percent (depending on plan quality).⁶²

Health Care Spending and the Medicare Program, Ch. 9 (June 2015) available at www.medpac.gov/documents/data-book/jun15databooksec9.pdf?sfvrsn=0.

⁵³ In 2015, 64 percent (10.7 million) of the 16.8 million Medicare Advantage enrollees were in HMO plans. KFF June 2015 Issue Brief at 3.

⁵⁴ *Id.* Most of the PPO enrollees (4 million) participate in local (i.e., countywide) PPOs; a much smaller number (1.2 million) enrollees participate in regional PPOs. *Id.*

⁵⁵ *Id.*

⁵⁶ MedPAC, *Report to the Congress*, *supra*, Ch. 13, at 319.

⁵⁷ See Competitive Impact Statement, *United States v. Humana*, *supra*, at 4.

⁵⁸ *Id.*

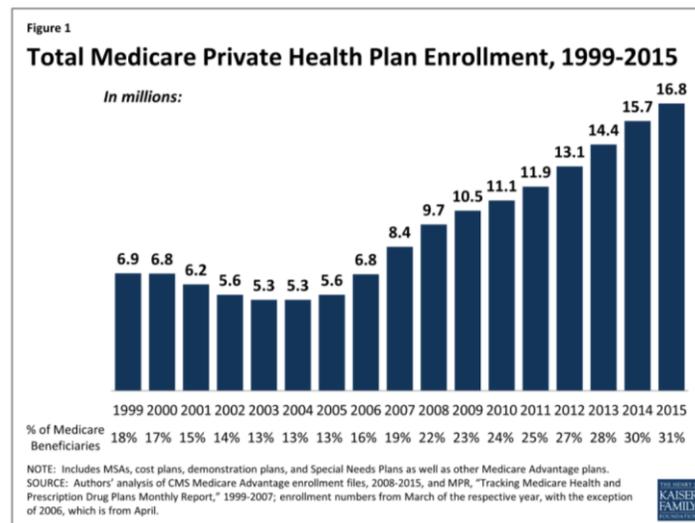
⁵⁹ *Id.*

⁶⁰ See Competitive Impact Statement, *United States v. UnitedHealth*, *supra*, at 6; see also Competitive Impact Statement, *United States v. Humana*, *supra*, at 4-5 (the rebate causes Medicare Advantage plans to “compete for enrollment by lowering costs, lowering premiums, increasing benefits, and improving performance”).

⁶¹ This was the figure in 2009. See U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *The Medicare Advantage Program in 2014*, (April 7, 2014) at 9, available at http://aspe.hhs.gov/sites/default/files/pdf/76846/ib_MedicareAdvantage.pdf.

⁶² MedPAC, *Medicare Advantage Program Payment* (rev’d Oct. 2014), available at www.medpac.gov/documents/payment-basics/medicare-advantage-program-payment-system-14.pdf?sfvrsn=0.

Not surprisingly, before the ACA took effect the Congressional Budget Office (CBO) projected that these changes would reduce enrollment.⁶³ Those predictions were wrong: enrollment in Medicare Advantage plans has *increased*, not decreased, since passage of the ACA. A table included in a recent issue brief published by the Kaiser Family Foundation shows this:⁶⁴



This enrollment increase has occurred at the same time that CMS has ratcheted down the payments to Medicare Advantage plans from the average of 114 percent of the amount expended per fee-for-service enrollee in 2009,⁶⁵ to just 102 percent in 2015.⁶⁶ And, while total Medicare Advantage enrollment has been growing quickly, and is projected to continue to grow to 25 million over the next 10 years,⁶⁷ the number of Medicare Advantage plans is *declining*.⁶⁸

2. Medicare Advantage Constitutes A Separate Relevant Product Market

In each of the two recent cases in which the Department focused on the market for Medicare Advantage plans, it identified Medicare Advantage plans sold to individuals as the relevant product market. As the Department stated in the UnitedHealth/Sierra merger, Medicare

⁶³ CBO estimated 35 percent less enrollment in 2019 than otherwise would have been the case—about 4.8 million fewer enrollees. See CBO, *Comparison of Projected Enrollment in Medicare Advantage Plans and Subsidies for Extra Benefits Not Covered by Medicare*, at 2, available at www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/macomparisons.pdf

⁶⁴ KFF June 2015 Issue Brief at 2 (Fig. 1).

⁶⁵ Kaiser Family Foundation, *The Role of Medicare Advantage*, Slide 4 (Ex. 3), available in <http://kff.org/slideshow/the-role-of-medicare-advantage/>.

⁶⁶ MedPAC, *Report to the Congress: Medicare Payment Policy*, at 325 (March 2015) available at [www.medpac.gov/documents/reports/chapter-13-the-medicare-advantage-program-status-report-\(march-2015-report\).pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/chapter-13-the-medicare-advantage-program-status-report-(march-2015-report).pdf?sfvrsn=0) (Table 13-4).

⁶⁷ *The Role of Medicare Advantage*, *supra*, Slide 2 (Ex. 1).

⁶⁸ Gretchen Jacobson, Tricia Neuman, and Anthony Damico, Kaiser Family Foundation Issue Brief, *What's In and What's Out? Medicare Advantage Market Entries and Exits for 2015* (Oct. 23, 2014) at 2, available at <http://files.kff.org/attachment/medicare-advantage-market-entries-and-exits-for-2015-issue-brief/>.

Advantage plans “offer lower co-payments, lower co-insurance, caps on total yearly out-of-pocket spending, prescription drug coverage, vision coverage, health club memberships, and other benefits that traditional Medicare does not cover.”⁶⁹ Similarly, in the Humana/Arcadian merger, the Department found Medicare Advantage plans:

Offer substantially richer benefits at lower costs to enrollees than traditional Medicare does with or without a Medicare Supplement or Medicare prescription drug plan, including lower copayments, lower coinsurance, caps on total yearly out-of-pocket costs, prescription drug coverage, and supplemental benefits that traditional Medicare does not cover, such as dental and vision coverage, and health club memberships.⁷⁰

The fact that Medicare Advantage plans combine in one product benefits that an enrollee in traditional Medicare must assemble from a variety of sources is yet another significant feature that distinguishes these plans from traditional Medicare. As the Department observed in the Humana/Arcadian merger, “Seniors enrolled in Medicare Advantage plans also often value that they can receive all of these benefits through a single plan and that Medicare Advantage plans manage care in ways that traditional Medicare does not.”⁷¹ One-stop shopping is of real value in many markets,⁷² but particularly here, where consumers are older, the products they must compare differ widely, and pricing comparisons are extremely difficult, not least because consumers frequently do not know what services they will require in the year ahead.⁷³ The cap on financial risk similarly distinguishes Medicare Advantage products from traditional Medicare.

The sum of these features translates into a strong preference by many seniors for Medicare Advantage plans. As the Department concluded in the UnitedHealth/Sierra merger:

Due in large part to the lower out-of-pocket costs and richer benefits that many Medicare Advantage plans offer seniors over traditional Medicare, seniors in the Las Vegas area would not likely switch away from Medicare Advantage plans to traditional

⁶⁹ Competitive Impact Statement, *United States v. UnitedHealth*, *supra*, at 7; *see also* Competitive Impact Statement, *United States v. Humana*, *supra*, at 4.

⁷⁰ Competitive Impact Statement, *United States v. Humana*, *supra*, at 5.

⁷¹ *Id.*

⁷² *See* ABA Section of Antitrust Law, *Antitrust Law Developments* (7th ed. 2012) at 595-99 (broad recognition of cluster markets in industries including hospital services, financial services, office supply superstores, and others).

⁷³ *See generally* Gretchen Jacobson, Christina Swoope, Michael Perry, Mary Slosar, *How are seniors choosing and changing health insurance plans?*, Henry J. Kaiser Family Foundation (May 2014) at 12 (“Seniors say they have tried to compare the costs, coverage, and provider networks of plans, but find it frustrating and confusing”), available at <https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8589-how-are-seniors-choosing-and-changing-health-insurance-plans.pdf>.

Medicare in sufficient numbers to make an anticompetitive price increase or reduction in quality unprofitable.⁷⁴

Based on the same differentiating factors, the Department similarly concluded in the Humana/Arcadian merger that individual Medicare Advantage plans constituted a relevant product market.⁷⁵

Despite the changes to the Medicare Advantage program made by the ACA, the elements that supported the Department's conclusions in 2008 and 2012 that Medicare Advantage plans constitute a distinct relevant product market still are in place today: Medicare Advantage plans continue to offer richer benefits at lower costs than does traditional Medicare, even when the latter is supplemented by Medigap policies and Part D plans.⁷⁶ Moreover, the ACA did nothing to reduce the complexity that faces a senior as he or she attempts to weave together coverage for inpatient care, outpatient care, physician care, prescription drugs, vision care, dental care, and other necessary health care, from the various items on the traditional Medicare menu including Part A, Part B, Part D, and Medigap and other supplemental insurance policies. To further complicate matters, seniors simultaneously must attempt to select coverage in a way that does not leave the senior exposed to large deductibles, high coinsurance on Part B, and no out-of-pocket limits for those unfortunate enough to incur substantial health care expenses in a given year.

Not only has passage of the ACA *not* weakened the argument that Medicare Advantage plans constitute a separate relevant product market, subsequent events have strengthened the argument. As noted above, costs for the average Medicare Advantage enrollee are being brought in line with costs for the average traditional Medicare enrollee. The CBO predicted that with fewer dollars available, relative to traditional Medicare, Medicare Advantage plans could expect enrollment to decline as seniors opted out of Medicare Advantage and into traditional Medicare.⁷⁷ But as this differential has narrowed, enrollment—instead of declining—has *grown*.⁷⁸

It appears the vast majority of individuals enrolled in Medicare Advantage plans have stayed in Medicare Advantage plans, even as the dollars expended on them relative to expenditures on

⁷⁴ Competitive Impact Statement, *United States v. UnitedHealth*, *supra*, at 4-5.

⁷⁵ Competitive Impact Statement, *United States v. Humana*, *supra*, at 6 (“a small but significant increase in Medicare Advantage plan premiums or reduction in benefits is unlikely to cause a sufficient number of seniors in the relevant geographic markets to switch to traditional Medicare such that the price increase or reduction in benefits would be unprofitable”).

⁷⁶ See generally KFF June 2015 Issue Brief at 8-12.

⁷⁷ CBO, *Comparison of Projected Enrollment in Medicare Advantage Plans and Subsidies*; see generally KFF June 2015 Issue Brief at 1; 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* 48, 49 (Jan. 2015), available at <http://content.healthaffairs.org/content/34/1/48.full.pdf>.

⁷⁸ *Id.*

traditional Medicare beneficiaries have declined by about 10 percent.⁷⁹ One study confirmed that in any given year the odds of seniors switching between Medicare Advantage and traditional Medicare are small (and fewer switch from Medicare Advantage to the traditional program than vice versa).⁸⁰ Significantly, seniors are far less likely to switch from Medicare Advantage to traditional Medicare when other Medicare Advantage alternatives are available.⁸¹ “And the odds of switching from Medicare Advantage to traditional Medicare were higher in counties with fewer plans, less experienced plans, or lower Medicare Advantage penetration rates.”⁸²

These data suggest strongly that Medicare Advantage enrollees prefer a Medicare Advantage product to traditional Medicare. So long as other Medicare Advantage alternatives are available, they generally do not switch to traditional Medicare. Similarly, in each of the UnitedHealth/Sierra and Humana/Arcadian mergers, the Department found Medicare Advantage constitutes a relevant product market separate from traditional Medicare because seniors would not switch away from Medicare Advantage to traditional Medicare in sufficient numbers to defeat a small but significant price increase or quality decrease in Medicare Advantage.⁸³ The same is true today. The only difference is that the evidence that such switching will not occur is far stronger now than it was in 2008 or 2012.

B. Relevant Geographic Market

Consistent with the Department’s practice in the UnitedHealth/Sierra⁸⁴ and Humana/Arcadian⁸⁵ mergers, the relevant geographic markets in which to evaluate the proposed Aetna/Humana merger are at the county (or parish) level. CMS approves Medicare Advantage plans on a county-by-county basis,⁸⁶ and the vast majority of seniors may only enroll in a Medicare Advantage plan in the county in which they live.⁸⁷

⁷⁹ As discussed earlier, in 2009, on average, the government expended 14 percent more on Medicare Advantage enrollees than it did on traditional Medicare beneficiaries. By 2015, that average had shrunk to 102 percent – a reduction in the differential of 10.5 percent.

⁸⁰ 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* 48, 51 (Jan. 2015), available at <http://content.healthaffairs.org/content/34/1/48.full.pdf>.

⁸¹ *Id.* at 53.

⁸² *Id.*

⁸³ Competitive Impact Statement, *United States v. UnitedHealth*, *supra*, at 7; Competitive Impact Statement, *United States v. Humana*, *supra*, at 6.

⁸⁴ Competitive Impact Statement, *United States v. UnitedHealth*, *supra*, at 6.

⁸⁵ Competitive Impact Statement, *United States v. Humana*, *supra*, at 7.

⁸⁶ CMS examines network adequacy on a county-by-county basis. See “CY2015 MA HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance,” available at www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2015_MA_HSD_Network_Criteria_Guidance.pdf

⁸⁷ Almost 88 percent of all Medicare Advantage enrollment is in HMOs and local PPOs. See KFF June 2015 Issue Brief at 3. Seniors enroll in these at the county level. Regional PPOs (just 7 percent of all enrollment) may provide coverage on a regional basis, but their beneficiaries can enroll in a plan only in the service area in which they live. CMS, *Medicare Managed Care Manual*, Ch. 2, Medicare Advantage Enrollment and Disenrollment, § 20.2, www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/downloads/mc86c02.pdf.

C. Competitive Effects

Under the Merger Guidelines, a “highly concentrated market” is one where the Herfindahl-Hirschman Index (HHI) is 2500 or more.⁸⁸ “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.”⁸⁹ Consistent with this approach, our analysis identifies counties where (1) both Aetna and Humana have Medicare Advantage membership, (2) the post-merger HHI is at least 2,500, and (3) the merger produces an increase of at least 100 points.

The table below shows the substantial impact the Aetna acquisition of Humana would have on Medicare Advantage competition across the nation.⁹⁰ In 1,083 markets, the transaction would increase the HHI by at least 100 points and the post-merger HHI will top 2,500. In 924 of these markets, the transaction would increase the HHI by more than 200 points.

Table 1. Counties in which the Post-Merger HHI Exceeds 2,500 and Change in HHI Exceeds 100 for Medicare Advantage Lives

	HHI Delta Screen	
	>200	>100
Number of Counties	924	1,083
Aetna Membership	784,167	842,864
Humana Membership	1,612,941	1,878,082
Total Aetna/Humana membership	2,397,108	2,720,946
Membership to Divest (smaller plan)	581,050	610,278

Source: Centers for Medicare & Medicaid Services, June 2015 MA Enrollment by Contract/Plan/State/County.⁹¹

⁸⁸ Horizontal Merger Guidelines, U.S. Department of Justice and Federal Trade Commission (August 19, 2010) at § 5.3, available at www.justice.gov/atr/horizontal-merger-guidelines-08192010.

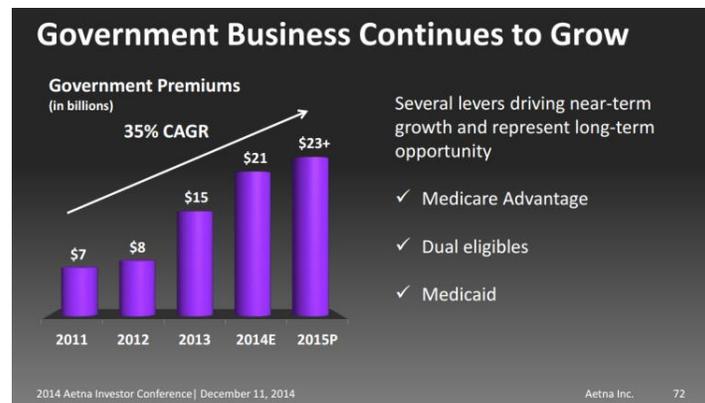
⁸⁹ *Id.*

⁹⁰ We exclude Special Needs Plans, as the Department did in both UnitedHealth/Sierra and Humana/Arcadian.

⁹¹ Available at www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County-Items/Monthly-Enrollment-by-CPSC-2015-06.html.

Aetna and Humana today provide health care coverage through Medicare Advantage for more than 4.3 million people.⁹² **More than 2.7 million of these seniors—almost two-thirds of both companies’ enrollees—live in relevant geographic markets that are or will be highly concentrated and in which the HHI increase will be at least 100 points.** The proposed acquisition threatens serious and widespread competitive harm.

The deal will not just eliminate current competition between Humana and Aetna, it will eliminate future competition between them. Humana is the second largest insurer of Medicare Advantage lives in the country.⁹³ Aetna is the fourth largest.⁹⁴ Aetna has promised investors it will continue to grow its Medicare Advantage business, as this chart from an Aetna investor conference held in December 2014 makes clear:⁹⁵



The merger would eliminate the possibility of competition between Aetna and Humana in markets which Aetna plans to enter. The Department should study carefully Aetna’s (and Humana’s) expansion plans to determine the degree to which both current and future competition will be sacrificed should this deal be completed.

⁹² CMS, June 2015 MA Enrollment by Contract/Plan/State/County, available at www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDenrolData/Monthly-Enrollment-by-Contract-Plan-State-County-Items/Monthly-Enrollment-by-CPSC-2015-06.html.

⁹³ Anna Wilde Mathews, Liz Hoffman, Dana Mattioli, *With Merger Deal, Aetna, Humana Get Ahead of the Pack*, Wall Street Journal (July 6, 2015), available at www.wsj.com/articles/with-merger-deal-aetna-humana-get-ahead-of-the-pack-1436143581

⁹⁴ KFF June 2015 Issue Brief at Fig. 14. (The BCBS figure shown there adds together shares for the different Blue Cross and Blue Shield affiliates in the U.S.)

⁹⁵ Aetna, 2014 Investor Conference (Dec. 11., 2014), at slide 72 available at <http://phx.corporate-ir.net/External.File?item=UGFyZW50SUQ9NTYzNTQ0fENoaWxkSUQ9MjYzODg0fFR5cGU9MQ==&t=1>; see also Aetna, 2013 Investor Conference (Dec. 12., 2013) at slide 107 (“Medicare Has Been a Growth Driver for Aetna”), available at www.aetna.com/investors-aetna/assets/documents/2013%20Investor%20Conference/2013-Investor-Conference-Presentation.pdf.

D. Aetna/Humana Will Not Show Efficiencies Overcome The Merger's Anticompetitive Effects

1. The Aggregation of Buyer Power Is Not An Efficiency And Will Harm Seniors

Aetna and Humana may argue that by merging they will obtain market power with which they can force hospitals and physicians to further lower their prices to the benefit of consumers.⁹⁶ The argument lacks merit.

Courts and commentators distinguish between monopsony power and countervailing power.⁹⁷ Monopsony power is the mirror image of monopoly power: a single buyer has monopsony power when it faces off against competitive suppliers who lack market power.⁹⁸ (And a small group of buyers in the same situation have oligopsony power.)⁹⁹ A monopsonist maximizes profits by depressing prices below competitive levels. Suppliers react by reducing output. As the Department recognized in a prior acquisition by Aetna, the exercise of monopsony power by an insurer harms consumers because it depresses the supply of providers (and potentially of other health care resources) below competitive levels.¹⁰⁰ Countervailing power is the use of buyer power against a supplier with market power. Some argue countervailing power may cause a supplier with market power to lower its price closer to the competitive level.¹⁰¹ But, as one law professor who has written extensively on buyer power notes, “the exercise of countervailing power is not always procompetitive.”¹⁰² As this commentator points out:

[A] merger that is large enough to increase buyer power materially may harm competition in multiple ways. First, it may create monopsony power and enable the merged firm to exploit small, relatively powerless providers. Second, the merger may create downstream market power, which could offset the desirable effects of countervailing power and raise premiums to consumers. Finally,

⁹⁶ Several commentators have made this argument. *See, e.g.,* Victor Fuchs, Peter Lee, *A Health Side of Insurer Mega-Mergers*, Wall Street Journal (Aug. 26, 2015), available at www.wsj.com/articles/a-healthy-side-of-insurer-mega-mergers-1440628597. Whether Aetna would make this argument is less clear: the company's CEO is on record saying so long as a market evolves toward capitation and away from fee-for-service, “a [provider] monopoly or oligopoly in a marketplace is a good thing.” Aetna, 2014 Investor Conference (Dec. 11, 2014) (statement made on audio portion at slide 35) available at <http://edge.media-server.com/m/p/eebugf92/lan/en>.

⁹⁷ *See, e.g.,* John B. Kirkwood, *Powerful Buyers and Merger Enforcement*, 92 B.U. L. REV. 1485, 1493-1512 (2012).

⁹⁸ *See Improving Health Care: A Dose of Competition*, Department of Justice & Federal Trade Commission, Improving Health Care: A Dose of Competition 29 (July 2004), Ch. 6 at 13, available at www.justice.gov/sites/default/files/atr/legacy/2006/04/27/204694.pdf.

⁹⁹ *Id.* at n.84.

¹⁰⁰ Complaint, *United States v. Aetna Inc. and The Prudential Insurance Co.*, No. 3-99CV 1398-H, at ¶¶ 30-33 (June 21, 1999), Competitive Impact Statement at 9-12 (July 16, 1999), available at www.justice.gov/atr/case/us-v-aetna-and-prudential-insurance-company; *see also United States v. UnitedHealth Group, Inc., and PacifiCare Health Systems, Inc.*, Civil Action No. 1:05CV02436, Complaint ¶ 5 (Dec. 20, 2005, D.D.C. 2005), available at <http://www.justice.gov/atr/case/us-v-unitedhealth-group-inc-and-pacificare-health-systems-inc>.

¹⁰¹ *Dose of Competition*, Ch. 6 at 14, n.86.

¹⁰² John B. Kirkwood, *Buyer Power and Healthcare Prices*, Wash. L. Rev. (forthcoming) at 10 n.32.

the merger might create countervailing power but the merged firm might exercise it in anticompetitive ways, harming consumers or small providers. ***Because a merger of large insurance companies is likely to produce at least one of these anticompetitive outcomes, allowing major insurers to combine does not appear to be a promising way of lowering healthcare prices.***¹⁰³

This conclusion simply reinforces the wisdom of the position taken by the antitrust enforcement agencies a decade ago, when they published their seminal study on competition in health care: “Countervailing power should not be considered an effective response to disparities in bargaining power between payors and providers.”¹⁰⁴

2. Entry

As observed in our analysis of the Anthem/Cigna merger, any argument that entry is sufficient to overcome the otherwise anticompetitive effects of a health insurer merger should be considered (in the words of a former Acting Assistant Attorney General in charge of the Division) “carefully and with some skepticism.”¹⁰⁵

The Department recognized in the Michigan MFN case that effective entry into a commercial health insurance market requires that “a health insurer contract with broad provider networks and obtain hospital prices and discounts at least comparable to the market’s leading incumbents.”¹⁰⁶ The same applies to an insurer seeking to enter a Medicare Advantage market. In fact, even if the

¹⁰³ *Id.* at 7-8 (emphasis added and footnotes omitted).

¹⁰⁴ *Dose of Competition*, Executive Summary at 27 (8th Observation). Although this was discussed primarily in the context of provider pleas that they be allowed to exercise countervailing power in negotiations with insurers, the logic applies equally against an assertion by insurers that they be allowed to merge to obtain power to use against providers. In fact, the enforcement agencies have responded to the argument that providers ought to have countervailing power to offset situations where insurers gain monopsony power by asserting “antitrust enforcement to prevent the unlawful acquisition ... of monopsony power by insurers is a better solution than allowing providers to exercise countervailing power.” *Id.* Ch. 3 at 21.

¹⁰⁵ Pozen at 7. *See also* remarks of Christine Varney, then Assistant Attorney General of the DOJ’s Antitrust Division, at a joint American Bar Association/American Health Lawyers Association Antitrust in Healthcare Conference, (May 24, 2010), available at <http://www.justice.gov/atr/speech/antitrust-and-healthcare>.

¹⁰⁶ Complaint, *U.S. v. Blue Cross and Blue Shield of Michigan*, No. 2:10-cv-14155-DPH-MKM (Oct. 18, 2010) at ¶ 35, available at www.justice.gov/atr/case/us-and-state-michigan-v-blue-cross-blue-shield-michigan. The Department also noted that entry was difficult (in fact, efforts to enter were demonstrably unsuccessful) in the complaint filed against a payer and five hospitals for colluding to lessen competition in the health insurance market in Montana. *U.S. and State of Montana v. Blue Cross and Blue Shield of Montana, et. al.*, Case No.1:11-cv-00123-RFC (Nov. 8, 2011), available at www.justice.gov/atr/case/us-and-state-montana-v-blue-cross-blue-shield-montana-inc-et-al. *See also United States v. Aetna Inc. and Prudential Insurance Co. of Am.*, Complaint at ¶ 23 (finding that it was unlikely that new companies would enter or that existing insurers providing other products would shift resources to provide products competitive with the newly formed Aetna/Prudential in Houston and Dallas “because of the costs and difficulties of doing so”).

insurer already has a commercial product in the same relevant geographic market, entering the Medicare Advantage market may present some challenges.

In the Analysis to Aid Public Comment filed in the Humana/Arcadian merger, the Department took note that competition from existing Medicare Advantage plans and new entrants “is unlikely to prevent anticompetitive effects in each relevant geographic market. Entrants face substantial cost, reputation, and distribution disadvantages that will likely make them unable to prevent Humana from profitably raising premiums or reducing benefits in the relevant geographic markets.”¹⁰⁷ The very same allegation was made earlier in the UnitedHealth/Sierra merger.¹⁰⁸

E. Remedies

Aetna and Humana may argue that divestitures will remedy the competitive problems identified by the Department. Both the UnitedHealth/Sierra and Humana/Arcadian mergers were permitted to proceed on condition that the parties divest portions of their individual Medicare Advantage lines of business. In those cases, however, the mergers threatened competitive harm in only a few relevant geographic markets. UnitedHealth’s proposed acquisition of Sierra affected Medicare Advantage patients in just two counties. In the Humana/Arcadian transaction, the Department identified 45 counties in which the merger would lessen competition, affecting approximately 50,000 Medicare Advantage enrollees. Here, by contrast, the proposed transaction between Aetna and Humana would substantially lessen competition in **1,083 counties** with **over 2.7 million Aetna and Humana members**. (See Table 1.)

Even if it were feasible, it would be a staggering task to develop, implement and supervise a divestiture package that would remedy harm to competition over such a broad area. Our analysis shows the 1,083 affected counties are in 38 states.

The Department has never before been faced with a merger that threatens to destroy competition in the Medicare Advantage market to the extent promised by this transaction. The scope of the likely competitive harm here is so broad and so deep that the amount of divestitures required to preserve and grow competition may not be feasible from a practical standpoint or even preserve the purported business benefits of the transaction.¹⁰⁹

¹⁰⁷ Competitive Impact Statement, *United States v. Humana*, at 8.

¹⁰⁸ Competitive Impact Statement, *United States v. UnitedHealth*, at 8-9.

¹⁰⁹ The federal antitrust enforcement agencies have opposed mergers where the divestitures that might otherwise have been required to preserve competition were so numerous as to cast serious doubt on the use of divestitures as a remedy. *See, e.g., FTC v. Sysco Corp.*, No. 15-cv-256-APM, 2015 U.S. Dist. LEXIS 83482, at *76–78 (D.D.C. June 23, 2015); *United States v. AT&T Inc. and T-Mobile*, Case: 1:11-cv-01560 (D.D.C. Aug. 31, 2011), available at www.justice.gov/atr/case/us-and-plaintiff-states-v-att-inc-et-al; Press Release, Department of Justice, Blue Cross Blue Shield of Michigan and Physicians Health Plan of MidMichigan Abandon Merger Plans: Decision to Abandon Deal Follows Justice Department’s Decision to Challenge the Acquisition (Mar. 8, 2010). www.justice.gov/opa/pr/blue-cross-blue-shield-michigan-and-physicians-healthplan-mid-michigan-abandon-merger-plans.

3. Conclusion

The proposed Aetna/Humana merger threatens substantial and irreversible harm to competition in critically important markets for Medicare Advantage plans across the country. In the earlier acquisition of Arcadian by Humana, the Department recognized that Medicare Advantage insurers “compete against each other by offering plans with frequently low or no premiums, reducing copayments, eliminating deductibles, lowering annual out-of-pocket maximum costs, managing care, improving drug coverage, offering desirable benefits, and making their provider networks more attractive to potential members.”¹¹⁰ The Department warned that if the merger proposed there were completed, the loss of “competition likely would result in higher premiums and reduced benefits for seniors enrolled in Medicare Advantage plans in the relevant geographic markets.”¹¹¹

The same consequences would follow here if Aetna and Humana are permitted to close the transaction. Today, however, unlike the “thousands of seniors” who would have been affected had the Department not intervened in the Humana/Arcadian merger,¹¹² millions of seniors will be adversely affected should the Aetna/Humana merger proceed as proposed.

¹¹⁰ Competitive Impact Statement, *United States v. Humana*, at 8.

¹¹¹ *Id.*

¹¹² Complaint, *United States v. Humana* at ¶ 4.



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By Email and Courier

August 5, 2015

The Honorable William Baer
Assistant Attorney General
United States Department of Justice Antitrust Division
950 Pennsylvania Avenue, N.W.
Washington, D.C., 20530

Dear Assistant Attorney General Baer:

I am writing on behalf of the nearly 5,000 member hospitals, health systems and other health care organizations, and 43,000 individual members of the American Hospital Association (AHA) regarding the proposed acquisitions involving four of the five major commercial health insurance companies in the United States: Anthem's proposed acquisition of Cigna and Aetna's proposed acquisition of Humana. Because the size and scope of these proposed acquisitions is so enormous and their potential anticompetitive impact on access, affordability and innovation is so profound, we will address them in separate letters in the knowledge that the Antitrust Division of the Department of Justice (Department) has indicated it will likely consider them collectively. This letter will focus on the proposed Anthem/Cigna deal.

We endorse the Department's often stated position that reforms in the health insurance industry are dependent on vigorous antitrust enforcement, particularly those involving significant commercial insurers where there is the very real potential for those deals to substantially reduce competition and substantially diminish the insurers' willingness to be innovative partners with providers and consumers in transforming care. We believe the announced deals cited above have that potential and, therefore, merit the closest scrutiny to determine whether remedies, such as divestitures, have any chance of ameliorating the enduring damage they could do as a result of the loss of such significant competition.

While some are comparing these acquisitions to those in the hospital sector, we submit that the antitrust issues for these transactions are fundamentally different. The size, scope and enduring impact of the announced deals far surpass any hospital merger. These transactions will combine four of the five national health insurance companies, with effectively no possibility that existing firms could replicate their size and scope. As the Department has long recognized, there are substantial barriers to entry in the health insurance sector (*United States and the State of*



Michigan v. Blue Cross Blue Shield of Michigan and Remarks by Sharis A. Pozen on Competition and Health Care: A Prescription for High-Quality Affordable Care, March 19, 2012). Moreover, the seeming underlying business case for them – increasing “top-line” revenues and profits through acquisition rather than competition without offsetting demonstrable efficiencies – is fundamentally different than that for transactions in the hospital sector. The hospital sector is undergoing profound structural changes, driven by the need to take on risk as the field moves away from fee-for-service payments toward population health, offer integrated clinical care, and provide financially failing facilities with the resources they require to survive and continue to serve their communities. Yet despite those pressures, the growth in hospital spending is at historic lows, which is entirely inconsistent with claims from commercial insurers about the impact of hospital transactions (*Bureau of Labor Statistics Producer Price Index data, 2014-2015, for Hospitals (622)*).

The attached analysis details the competitive issues that the Department will consider as it reviews these deals and the precedents that suggest both are, and should be, at risk. Regulations in the Affordable Care Act, such as the Medical Loss Ratio (MLR), do not warrant scaled-back application of the antitrust laws. A keystone component of that act is competition, and the MLR requirements do nothing to prevent the combined firms from increasing prices or reducing competition in service, quality, plan design and the like.

We look forward to working with the Department throughout its investigation of these insurance deals. To that end, we will be contacting the Department to request meetings with staff and top officials to more fully discuss our concerns and ways in which we can be of assistance.

For more information, you can contact me directly at mhatton@aha.org or (202) 626-2336.

Sincerely,

/s/

Melinda Reid Hatton
Senior Vice President & General Counsel

Attachment

Detailed Analysis of the American Hospital Association

On behalf of the nearly 5,000 members of the American Hospital Association (AHA), we urge that the Antitrust Division of the Department of Justice (Department) thoroughly investigate Anthem, Inc.'s (Anthem) planned \$54 billion acquisition of Cigna Corporation. There is a material risk that the transaction is likely to substantially reduce competition, in violation of Section 7 of the Clayton Act.¹ The potential harm to consumers from this loss of competition is large and durable. Because the two companies generate more than \$100 billion in combined revenues, even a modest price increase would cost consumers billions of dollars in higher health care costs.

The geographic breadth of the transaction's potential anticompetitive effects and the number of consumers at risk are also sweeping. The transaction threatens to reduce competition in the sale of commercial health insurance in at least 817 relevant geographic markets, defined as Metropolitan Statistical Areas (MSAs) or rural counties. In 600 of these markets, the transaction would result in a Herfindahl-Hirschman Index (HHI) in excess of 2,500 and a greater than 200-point HHI increase, which under the Department's and the Federal Trade Commission's (FTC) Horizontal Merger Guidelines (Merger Guidelines, or Guidelines) are market concentration levels and increases that the Department "presume[s] to be likely to enhance market power."² In an additional 217 markets, the transaction would result in a post-merger HHI in excess of 2,500 and a 100-200 point HHI increase, which the Guidelines say "potentially raise[s] significant competitive concerns."³ In these 817 at-risk markets the parties collectively serve 45 million consumers.

The risk of harm to these tens of millions of consumers is further enhanced because new entry is unlikely to prevent, or even partially offset, the transaction's potential anticompetitive effects. The Department has repeatedly stated in its court filings and in statements by the Department's leadership that there are substantial barriers to entry in the health insurance sector, including obtaining the necessary scale to form a full-service, cost-competitive provider network. As former Acting Assistant Attorney General Sharis Pozen explained, the Department "undertook an extensive review of entry and expansion in the health insurance industry" in 2011, and found that entry in the health insurance sector was often difficult, particularly in already concentrated markets, as is the case in many of the markets at issue here.⁴

The parties will no doubt argue that the transaction would produce offsetting efficiencies, but this is not likely. And it is even less likely that the combined companies would "pass through" any cost savings to consumers. As numerous economists have found, demand for health

¹ 15 U.S.C. § 18.

² *Merger Guidelines* § 5.3.

³ *Id.*

⁴ 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>.

insurance is inelastic,⁵ which reduces the incentive for large health insurance companies to pass through cost savings. The incentives to pass savings on to consumers are further reduced due to the opaqueness of the insurance markets and the fact that costs and benefits are not fully internalized by consumers.

Anthem and Cigna also will undoubtedly urge that the Department approve the merger after the parties agree to divestitures. It is far from clear that the parties could ever put forth a divestiture package that would reduce the transaction's likely anticompetitive effects. First, the Department has been rightly concerned that the acquirer of any divested lives be well-positioned to compete effectively in the local area. An existing presence in the market can often facilitate the success of a buyer. Accordingly, we have examined to what extent it is possible to eliminate the potentially anticompetitive overlaps through sales to an existing competitor without causing an increase in market concentration. Significantly, in the 817 at-risk markets, over half of the lives that need to be divested reside across 368 MSAs and rural counties with no divestiture possibility that is likely to preserve the pre-merger market structure.

Second, even if the parties somehow managed to maintain the structural status quo, the Department also must require, as it has in its recent enforcement actions, Anthem and Cigna to ensure that the buyers of any divested contracts have a *provider network of comparable cost and breadth* to that of the parties.⁶ Indeed, the Department has repeatedly recognized that in order for a health insurer to compete effectively, it must have a full-service, cost-competitive network of hospitals, physicians, and other health care providers.⁷

Third, the Department also should view any remedy proposal carefully because, regardless of the "fix" the parties ultimately propose, the transaction will inevitably eliminate a national health insurance company. The parties are two of only five national health insurance companies that remain today, and two of the other three (Aetna and Humana) also have entered into a consolidation agreement. Recent enforcement actions suggest that all possible relevant markets must be examined closely, particularly in a transaction of this magnitude, which can be challenged on the basis of reduced competition in a market for national customers.⁸ In particular, the Department should carefully investigate how this permanent loss of national competitors would affect competition for contracts with national and large regional employers. Obvious sources of evidence that the Department should analyze are the parties' "bid" files reflecting competition between them for these accounts.

⁵ See M. Kate Bundorf et al., *Pricing and Welfare in Health Plan Choice* 32 (Stanford Inst. for Economic Policy Research Discussion Paper No. 07-47, 2008), <http://www-siepr.stanford.edu/papers/pdf/07-47.pdf>; Su Liu & Deborah Chollet, *Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature* ix (Mathematic Policy Research Ref. No. 6203-042, 2006), <http://www.mathematica-mpr.com/publications/pdfs/priceincome.pdf>.

⁶ See Competitive Impact Statement at 17, *United States v. Blue Cross-Blue Shield of Montana*, No. 11-cv-123-RFC (D. Mont. Nov. 8, 2011).

⁷ See *id.*

⁸ See *FTC v. Sysco Corp.*, No. 15-cv-256-APM, 2015 U.S. Dist. LEXIS 83482, at *76–78 (D.D.C. June 23, 2015).

Finally, while the competitive overlap between the parties appears somewhat smaller in the sale of Medicare Advantage plans than in the commercial insurance market, the Department also should investigate carefully the transaction's effect on competition in the Medicare Advantage sector. Starting with the Department's challenge to UnitedHealthcare's acquisition of Sierra Health Services in 2008,⁹ the Department (working with the Center for Medicare & Medicaid Services) has scrutinized carefully the effect of consolidation of Medicare Advantage providers in order to preserve the benefits of competition for senior citizens that the program was designed to bring. The Department should continue this policy of protecting competition for the sale of Medicare Advantage plans both in its investigation of the Anthem/Cigna transaction, as well in its investigation of Aetna's proposed acquisition of Humana, which we will address in a separate letter.

1. The Parties

A. Anthem

Anthem is one of the largest health insurance companies in the United States. In 2014, Anthem generated approximately \$73 billion in revenues.

Anthem is investor-owned and publicly-traded, and operates plans under the Blue Cross (BCBS) brand in 14 states. The Anthem companies serve members as the Blue Cross licensee for California, and as the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as the Blue Cross Blue Shield licensee in 10 New York City metropolitan and surrounding counties and as the Blue Cross or Blue Cross Blue Shield licensee in selected upstate counties), Ohio, Virginia (excluding the northern Virginia suburbs of Washington, D.C.) and Wisconsin.

Anthem also conducts business through arrangements with other BCBS licensees in South Carolina and Texas; and through its Amerigroup subsidiary in Florida, Georgia, Kansas, Louisiana, Maryland, Nevada, New Jersey, New Mexico, New York, Tennessee, Texas and Washington. The company is licensed to conduct insurance operations in all 50 states through its subsidiaries.

Anthem has been strikingly successful on its own. In 2014, the company grew its membership by 1.8 million new members, including more than 700,000 members from the Public Exchanges, and surpassed 5 million members in its Medicaid business. In 2014 Anthem increased its revenues by nearly \$3 billion, or approximately 5 percent over the previous year. Moreover, the company "made and [is] continuing to make substantial investments in new capabilities that better serve [its] members and *will help drive future growth* [and it is] confident that by remaining disciplined, consistent and accountable for delivering results, [it] will achieve [its] goals."¹⁰

⁹ See Complaint, *United States v. UnitedHealth Group Inc.*, No. 08-cv-322 (D.D.C. Feb. 25, 2008).

¹⁰ Anthem, Inc., 2014 Annual Report 9 (2015).

Anthem reported 38.5 million members in its medical plans, as of June 30, 2015. Of these, 5.8 million were in Medicaid plans, 1.4 million in Medicare Advantage, 1.6 million in FEP, and 1.8 million in individual products. Approximately 29 million are commercial group members.¹¹

B. Cigna

Cigna also is one of the largest health insurance companies in the United States, with 15 million members in all 50 states. In 2014, Cigna generated approximately \$35 billion in revenues. Like Anthem, Cigna provides a wide range of commercial plans and has more than 14.2 million commercial members.¹²

Cigna also has been very successful on its own. Cigna's 2014 Annual Report states that in 2014 the company increased revenue by 8 percent and earnings per share by 9 percent last year. And over the last five years, Cigna "delivered compound annual growth of 14 percent for revenues and 14 percent for adjusted income from operations on a per share basis."¹³ Moreover, the 2014 Annual Report (which was issued months before the announcement of its transaction with Anthem) states that, on its own, Cigna expected to achieve substantial growth, such as:

- "Growing revenues by eight to ten percent in 2015;
- Doubling the size of [its] business over the next seven to eight years[;] and
- Delivering on [its] long-term Earnings Per Share objective of 10 to 13 percent compound growth on an annual basis."¹⁴

2. The Antitrust Laws Applied to Health Insurance Mergers

As noted in the 2004 report, *Improving Health Care: A Dose of Competition*, the federal antitrust agencies, for decades, have had a bipartisan "commitment to vigorous competition on both price and non-price parameters [] in health care."¹⁵ As the Agencies have explained, in this sector "[p]rice competition generally results in lower prices and, thus, broader access to health care products and services. Non-price competition can promote higher quality and encourage innovation."¹⁶

¹¹ Press Release, Anthem, Inc., Anthem Reports Second Quarter 2015 Results (July 29, 2015) <http://ir.antheminc.com/phoenix.zhtml?c=130104&p=irol-newsArticle&ID=2072061>.

¹² Press Release, Cigna Corp., Cigna Reports Strong Second Quarter 2015 Results, Affirms Increased Outlook (July 30, 2015) <http://newsroom.cigna.com/NewsReleases/Cigna-Reports-Strong-Second-Quarter-2015-Results--Affirms-Increased-Outlook.htm>.

¹³ Cigna Corp., 2014 Annual Report 3 (2015) (footnote omitted).

¹⁴ *Id.*

¹⁵ Dep't of Justice & Federal Trade Comm'n, *Improving Health Care: A Dose of Competition* 29 (July 2004), <http://www.justice.gov/sites/default/files/atr/legacy/2006/04/27/204694.pdf>.

¹⁶ *Id.* at 4.

The Affordable Care Act (ACA) has not diminished the importance of antitrust enforcement in the commercial health insurance sector. To the contrary, the Department's leadership has made clear that:

The success of health care reform will depend as much upon healthy competitive markets as it will upon regulatory change. If health care reform is to produce more efficient systems, bring health care costs under control, and provide higher-quality health care delivery, then we must vigorously combat anticompetitive mergers and conduct that harm consumers with responsible antitrust enforcement.¹⁷

The Department has primary responsibility for enforcing the antitrust laws in the health insurance sector.¹⁸ In this capacity, the Department has challenged transactions that cause a significant increase in market concentration and loss of localized head-to-head competition.¹⁹ In its enforcement actions, the Department has set forth a clear analytical framework for evaluating transactions, which it should apply rigorously in reviewing this transaction of unprecedented size and scope. We summarize that framework and then apply it to the Anthem/Cigna transaction to demonstrate the substantial risk that the transaction presents to competition and consumers.

A. Relevant Product Market

The Department has consistently recognized that group commercial health insurance is a well-defined antitrust-relevant product market. The Department has explained that, for individuals who obtain commercial health insurance through their employers, there are no reasonable competitive alternatives to group health insurance. This is because the closest alternative—individual health insurance—is typically much more expensive than group health insurance, in part because, while group health insurance is purchased using pre-tax dollars, individual health insurance is not.²⁰

The Department also has determined that individual (and relatedly, small group) insurance is a relevant antitrust product market. As the Department has found, “individual health insurance is the only product available to individuals without access to group coverage or

¹⁷ Pozen, *Competition and Health Care* at 19.

¹⁸ The FTC conducts the bulk of the antitrust investigations that involve hospitals.

¹⁹ See, e.g., Complaint, *United States v. Humana Inc.*, 12-cv-464 (D.D.C., Mar. 27, 2012) (Medicare Advantage); Complaint, *United States v. Blue Cross Blue Shield of Montana*, No. 11-cv-123-RFC (D. Mont. Nov. 8, 2011) (group commercial and individual insurance); Complaint, *United States v. UnitedHealth Group Inc.*, No. 08-cv-322 (D.D.C. Feb. 25, 2008) (Medicare Advantage); Complaint, *United States v. UnitedHealth Group Inc.*, No. 05CV02436 (Dec. 20, 2005) (large group commercial insurance; small group commercial health insurance); Complaint, *United States v. Aetna, Inc.*, No. 99 CV 1398-H (June 21, 1999) (commercial plans.) These enforcement actions reflect the Department's experience in the insurance sector, including its understanding that, unlike many industries, health insurance is characterized by strong and durable barriers to entry. See Complaint at ¶ 35, *United States v. Blue Cross Blue Shield of Michigan*, No. 10-cv-14155-DPH-MKM (E.D. Mich. Oct. 18, 2010).

²⁰ See Complaint at ¶¶ 21–24, *Blue Cross Blue Shield of Montana*.

government programs that allows them [(1)] to reduce the financial risk of adverse health conditions and [(2)] to have access to health care at the discounted prices negotiated by commercial health insurers.” The Department has explained that “[t]here are no reasonable alternatives to individual health insurance for individuals who lack access to group health insurance” because “[p]urchasing hospital services directly, rather than through a commercial insurer, is typically prohibitively expensive and [therefore] is not a viable substitute for group or individual health insurance.”²¹

Regardless of how the Department ultimately defines the product market, the Anthem/Cigna transaction is likely to reduce competition in the sale of commercial health insurance. As shown above and discussed further below, the transaction would produce substantial increases in concentration in the sale of commercial health insurance in substantial portions of the country. Moreover, the transaction is likely to have particularly large and wide-ranging anticompetitive effects in the sale of health insurance to employers who self-insure because both parties are particularly strong in the sale of such plans.

B. Relevant Geographic Market

To date, the Department has largely defined local relevant geographic markets in the health insurance sector. The rationale is that patients typically seek medical care close to their homes or workplaces and consequently “strongly prefer health-insurance plans with networks of hospitals and physicians that are close to their homes and workplaces.”²² As a practical matter, consumers will not select commercial health insurers that do not have a network of providers close to where they work and live.²³

The Department’s investigation of the Anthem/Cigna transaction should focus closely on the deal’s impact on local markets throughout the country. However, as discussed below, this transaction also raises substantial competitive concerns for reductions in competition for national and large regional customers.

C. Competitive Effects

Consistent with modern antitrust enforcement principles, the Department’s competitive effects analysis of health insurance transactions examines both market structure and direct evidence of competition in the markets.

Market structure analysis focuses on the number of competitors, market shares, and market concentration ratios, usually the HHI. The HHI is calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. The Merger Guidelines provide that a market whose HHI is above 2,500 is “Highly Concentrated.” The

²¹ Complaint at ¶¶ 22–23, *Blue Cross Blue Shield of Michigan*; see also Complaint at ¶¶ 25–26, *Blue Cross Blue Shield of Montana*.

²² Complaint at ¶ 27, *Blue Cross Blue Shield of Montana*.

²³ See *id.* at ¶¶ 27–29.

Guidelines further provide that “[m]ergers 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.”²⁴ 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.²⁵

The structural evidence strongly suggests that the Anthem/Cigna transaction will reduce competition in many geographic markets. Table 1 depicts the substantial increases in concentration that the transaction would produce.

Table 1
MSAs and Rural Counties in which the Post-Merger HHI Exceeds 2,500
for Commercial Lives

	HHI Delta Screen		Share Screen	
	>200	> 100	> 50%	> 35%
All Commercial Lives				
Number of MSAs	600	817	355	498
Total Commercially Insured				
Population	31,231,334	45,034,730	11,325,952	23,692,558
Anthem Membership	10,472,094	12,405,109	5,723,016	9,747,303
Cigna Membership	3,706,219	4,755,399	1,254,867	2,613,582
Membership to Divest (smaller plan)	2,942,351	3,721,670	1,191,751	2,288,825
Membership with no Potential Acquirer	1,675,275	2,040,397	954,116	1,156,554

In 600 markets, the transaction will produce a post-merger HHI of more than 2,500 with a 200-point increase, generating a presumption that the transaction will result in an increase in the parties’ market power. Significantly, the parties insure approximately *31.2 million* lives in these markets. In 217 markets, covering an additional *14 million* commercially insured individuals, the transaction will produce a post-merger HHI of 2,500 with a 100-200 point increase, indicating that the transaction raises significant competitive concerns for these consumers.²⁶

²⁴ *Merger Guidelines* § 5.3.

²⁵ *See id.*

²⁶ The calculations are based on data from January 2015 obtained from HealthLeaders-Interstudy Managed Market Surveyor, which provides information on the number of individuals who are enrolled in different health plan products by county and plan. Following Department precedent in previous investigations, we have calculated shares and HHI measures at the MSA level or, in the case of rural counties that are not part of an MSA, at the county level.

The competitive picture is equally concerning if one focuses on market shares. In 355 markets, the combined company would have a market share of at least 50 percent, and in 498 MSAs and counties, their combined share would exceed 35 percent.²⁷

Because the Department often focuses on the degree of head-to-head competition between the merging parties, we also have examined the transaction's effects on competition in the sale of commercial health insurance to self-insured employers, which is the area of greatest competitive overlap. The antitrust concerns are not lower for consolidations of health insurers that sell policies to self-insured employers (often called Administrative Services Only plans, or ASO). Again, an essential service that health insurers provide is access to a provider network at competitive rates. Increasing the market power of a provider of self-insured products would allow the carrier to increase the administrative and other service fees that self-insured employers need to pay in order to obtain access to the carrier's provider network and raises other competitive concerns that negatively impact consumers.

As shown in Table 2, the competitive picture is even worse when one focuses on the sale of commercial insurance to self-insured employers.

Table 2
MSAs and Rural Counties in which the Post-Merger HHI Exceeds 2,500
for Commercial ASO Lives

	HHI Delta Screen		Share Screen	
	>200	> 100	> 50%	> 35%
Commercial ASO Lives				
Number of MSAs	1,009	1,177	460	730
Total Commercially Insured				
Population	38,336,781	43,919,746	14,928,252	24,741,274
Anthem Membership	10,915,580	11,314,078	6,818,499	9,275,512
Cigna Membership	6,385,014	6,960,004	2,450,874	4,265,669
Membership to Divest (smaller plan)	4,358,445	4,679,006	2,053,778	3,247,357
Membership with no Potential Acquirer	2,762,697	3,009,489	1,830,490	2,245,286

Limiting the analysis to self-insured lives, there are 1,009 MSAs and rural counties in which the merger would result in an HHI exceeding 2,500 with an HHI increase of at least 200, covering 38.3 million self-insured commercial lives who reside in these markets. And there are 1,177 local geographic areas, with nearly 44 million self-insured lives, for which the HHI increase exceeds 100 (and the post-merger HHI is at least 2,500). In 460 of these markets, the combined Anthem-Cigna share of self-insured commercial business would be at least 50 percent.

²⁷ We also apply the HHI > 2500 threshold to these calculations.

D. Entry

The parties will no doubt argue that changes in the health care landscape would prompt entry if they were to attempt to exercise market power. Former Acting Assistant Attorney General Pozen appropriately cautioned that the Department should review such claims “carefully and with some skepticism.”²⁸ This is in part because smaller entrants and incumbents often lack the volume to obtain prices from providers that are comparable to insurers with large market positions. The Department’s challenge to Blue Cross Blue Shield of Michigan’s use of most-favored nation clauses clearly set forth this market dynamic:

Blue Cross’ market power in each of the alleged markets is durable because entry into the alleged [commercial health insurance] markets is difficult. Effective entry into or expansion in commercial health insurance markets requires that a health insurer contract with broad provider networks and obtain hospital prices and discounts at least comparable to the market’s leading incumbents.²⁹

Indeed, one of the central insights of antitrust analysis of the health insurance markets over the last several decades is that Judge Easterbrook was likely incorrect at the time (and is certainly incorrect today) in characterizing the key input of the health insurance market as “capital” for spreading financial risk.³⁰ Instead, as the Department has argued in its court filings, “the core component of health insurance products today is access to a local network of health care providers at rates far lower [than] those that an individual could negotiate directly.”³¹

Brand also is a substantial entry barrier in the commercial health insurance markets. Because of the importance of health insurance, and the often substantial transition costs from switching plans, employers and individuals are often very reluctant to switch to a company that lacks an established brand in the relevant geographic market. Even companies with strong positions in other regions can founder in markets in which they lack a strong track record of providing high-quality services.³²

²⁸ Pozen, *Competition and Health Care* at 7.

²⁹ Complaint at ¶ 35, *United States v. Blue Cross Blue Shield of Michigan*.

³⁰ *Ball Mem’l Hosp. v. Mut. Hosp. Ins. Inc.*, 784 F.2d 1325, 1335 (7th Cir. 1986) (affirming district court finding “that insurers need only a license and capital, and that firms such as Aetna and Prudential have both[, and that] [t]here are no barriers to entry”).

³¹ Plaintiff United States of America’s Memorandum In Opposition to Defendant Blue Cross Blue Shield of Michigan’s Motion to Dismiss the Complaint With Prejudice at 13, *United States v. Blue Cross Blue Shield of Michigan*, No. 10-cv-14155-DPH-MKM (E.D. Mich. Oct. 18, 2010). Moreover, the Tenth Circuit disagreed with *Ball Memorial* and recognized the importance of Blue Cross of Kansas’s provider network, including direct contracts with local hospitals, as a source of competitive advantage over other insurers that could not until recently contract directly. *Reazin v. Blue Cross and Blue Shield of Kansas*, 899 F.2d 951, at 971–72 & n.32 (10th Cir. 1990).

³² See Pozen, *Competition and Health Care* at 7 (“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.”)

E. Remedies

The parties also will no doubt propose to solve any overlaps that the Department views as problematic through one-off divestiture remedies. The Department should view such remedies with skepticism. Indeed, the Department has blocked outright health insurance transactions when it doubted that a remedy could reliably fix the lost competition, as it did when Blue Cross Blue Shield of Michigan attempted to purchase Physicians Health Plan of Mid-Michigan.³³

Our analysis demonstrates that it will be, at best, challenging for Anthem and Cigna to devise remedies that will maintain the competitive status quo. First, Table 1 provides estimates of the number of lives that would need to be divested to maintain the current market structure. Recognizing the Department's concern that the acquirer of any divested lives be equipped to compete effectively in the local area, without at the same time raising additional structural concerns, we have identified those local areas in which there is no potential acquirer who currently accounts for at least 5 percent of the covered lives and would not result in a post-acquisition HHI of 2,500 with a change in HHI of at least 100. Based on these minimal criteria, there is no viable divestiture candidate for approximately 55 percent of the lives to be divested (or 2 million consumers), who reside across 368 MSAs and rural counties.

Second, even assuming that one could solve the "nominal" structural problem through the divestitures, the Department must still ensure, as it has in the past, that the *divesting parties guarantee that the purchaser of any divested assets has a cost-competitive comparable network of hospitals and physicians*. As the Department explained in its Competitive Impact Statement for its challenge to the Blue Cross-Blue Shield of Montana/New West transaction:

*Most importantly, Sections IV(G)–(I) [of the Final Judgment] ensure that the acquirer has a cost-competitive health-care provider network. To compete effectively in the sale of commercial health insurance, insurers need a network of health-care providers at competitive rates because hospital and physician expenses constitute the large majority of an insurer's costs. By requiring New West and the hospital defendants to help to provide the acquirer with a cost-competitive provider network, Sections IV(G)–(I) help ensure that the acquirer will be able to compete as effectively as New West before the parties entered the Agreement.*³⁴

In the *Blue Cross-Blue Shield of Montana* case, because of the importance of ensuring that the acquirer had a cost-competitive network, the Department required that the hospital defendants, which owned New West, enter into three-year contracts with the buyer of the

³³ See Press Release, Dep't of Justice, Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans: Decision to Abandon Deal Follows Justice Department's Decision to Challenge the Acquisition (Mar. 8, 2010), <http://www.justice.gov/opa/pr/blue-cross-blue-shield-michigan-and-physicians-health-plan-mid-michigan-abandon-merger-plans>.

³⁴ Competitive Impact Statement at 17, *Blue Cross-Blue Shield of Montana*, No. 11-cv-123-RFC (D. Mont. Nov. 8, 2011) (emphasis added).

divested assets that were “substantially similar to their existing contractual terms with New West.” The Department declared these contractual guarantees to be “vital” to ensuring the effectiveness of the remedy: “Because these three-year contracts provide the acquirer with a cost structure comparable to New West’s costs, they position the acquirer to be competitive selling commercial health insurance in all four geographic markets.”³⁵

F. Medical Loss Ratio

Finally, Anthem and Cigna may argue that the Department should lower the antitrust bar because of the margin restrictions imposed by the ACA’s Medical Loss Ratio (MLR) provisions, which require that fully insured health plans spend a minimum percentage of their premiums (less taxes, licenses, and regulatory fees) on medical services and quality improvement initiatives. In particular, the ACA requires that large group insurers spend at least 85 percent of their net premium dollars on these items, while small group and individual insurers must devote at least 80 percent of them.³⁶

The Department should reject this argument, as it has in the past. First, MLR requirements only apply to fully insured products. They do not cover at all the substantial competition between the parties for self-insured products. Second, the MLR requirements are not price-caps. Nothing in the requirements prevents an insurance company from increasing its costs, in order to increase prices and margins. Third, the requirements do not prevent health insurance companies from exercising market power by restricting provider networks or reducing service levels so long as they meet the minimum MLR thresholds.

3. Conclusion

A competitive commercial health insurance market is essential for access, affordability and innovation in the health care sector. Anthem’s proposed acquisition of Cigna presents a substantial risk to such competition on an unprecedented national scope. The AHA is confident that the Department will work to protect consumers by vigorously investigating the transaction.

³⁵ *Id.* at 17–18.

³⁶ *See* ACA, Pub. L. No. 111-148, § 10101(f), 124 Stat. 119, 886 (2010) (amending Public Health Service Act § 2718(b)(1)(A), 42 U.S.C. 300gg-18).