

**HEALTHY COMPETITION?
AN EXAMINATION OF THE PROPOSED
HEALTH INSURANCE MERGERS AND THE
CONSEQUENT IMPACT ON COMPETITION**

HEARING
BEFORE THE
SUBCOMMITTEE ON
REGULATORY REFORM,
COMMERCIAL AND ANTITRUST LAW
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HEALTHY COMPETITION? AN EXAMINATION OF THE PROPOSED HEALTH INSURANCE MERGERS AND THE CONSEQUENT IMPACT ON COMPETITION

TUESDAY, SEPTEMBER 29, 2015

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON REGULATORY REFORM,
COMMERCIAL AND ANTITRUST LAW
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to call, at 2:09 p.m., in room 2141, Rayburn Office Building, the Honorable Thomas Marino (Chairman of the Subcommittee) presiding.

Present: Representatives Marino, Goodlatte, Collins, Waters, Ratcliffe, Bishop, Johnson, Conyers, DelBene, Jeffries, Cicilline, and Peters.

Staff Present: (Majority) Anthony Grossi, Counsel; Andrea Lindsey, Clerk; and (Minority) Slade Bond, Counsel.

Mr. MARINO. The Subcommittee on Regulatory Reform, Commercial and Antitrust Law will come to order. Good afternoon, everyone.

Without objection, the Chair is authorized to declare recesses of the Committee at any time. We welcome everyone to today's hearing, and I now recognize myself for an opening statement.

We are here today to examine the proposed mergers between the health insurance companies Aetna and Humana, and Anthem and Cigna. Collectively, they currently provide health insurance products to over 85 million Americans, and they are among the largest health insurance companies in the country.

Undoubtedly, it should be determined whether these transactions have the potential to significantly alter the competitive landscape of the health insurance industry. In examining this industry, it is important to note that the health insurance market includes a number of different products. There are insurance products for individuals and families that can be purchased directly from the marketplace, insurance that companies purchase to offer to their employees, and government-funded insurance that private companies help to administer.

These insurance products are often local in nature, since patients generally visit the doctors and hospitals near where they work and

live. However, these products are often provided by insurers with a strong national or regional presence.

Aetna, Humana, Anthem, and Cigna essentially all offer the same variety of health insurance products. However, each company has a particular business line that they emphasize or specific geographic markets in which they operate.

Aetna is a significant provider of commercial health insurance, Humana places a strong emphasis on its Medicare Advantage products, and Anthem and Cigna largely operate in different geographical regions.

Following the announcements of the proposed mergers, several commentators issued statements raising concerns about the two transactions. Associations representing hospitals and doctors are among that group, and they are urging the Department of Justice to review thoroughly the proposed deals. They appear before us today to express those views and provide additional detail regarding their concerns.

We are not here today to issue any definitive judgments about whether DOJ should take any particular actions regarding these mergers. Instead, the hearing serves as a public and transparent platform from which we will hear from those who believe the deal will benefit consumers, and those who believe the merger may negatively impact competition within the health insurance marketplace.

I look forward to today's discussions, and I yield back the balance of my time.

The Chair now recognizes the Ranking Member of the Subcommittee on Regulatory Reform, Commercial and Antitrust Law, Congressman Johnson from the State of Georgia, for his opening statement.

Congressman?

Mr. JOHNSON. Thank you, Mr. Chairman, for holding this very important hearing.

Today's hearing is an important opportunity to consider the effects of Anthem's proposed acquisition of Cigna, and Aetna's proposed acquisition of Humana, on consumers' access to health insurance coverage that is both affordable and effective. I have long supported vigorous enforcement and promotion of competition in the health care industry for both providers and insurers. However, as George Slover, Consumers Union's senior policy counsel, noted in his testimony before the Senate Judiciary Subcommittee on Antitrust and Consumer Protection last week, over a century of experiences demonstrate that "you cannot run the health care system on competition alone and just allow the free market to go where it will."

Enactment of the Affordable Care Act was recognition that competition alone did not ensure accountability in the health care marketplace, greater savings to consumers, or equal treatment of consumers by insurance providers. Smart health care regulation was critical to keeping premiums down, to ending discrimination against Americans with pre-existing conditions, and to ensuring the common good for millions of consumers. After all, what good is having numerous options for health insurance providers, if none will provide coverage for treating your child's condition?

It is also clear that the Affordable Care Act both depends on and promotes competition in the health care marketplace, as Professor Tim Greaney noted in our recent hearing on competition in the health care marketplace. Professor Leemore Dafny, a leading health care economist, has also testified that the smart regulation inherent to the Affordable Care Act promotes competition in the insurance industry through a number of mechanisms, including product standardization and plan certification, which reduced the hurdle to entry posed by the need to establish a credible reputation, and via health insurance marketplaces, which reduce marketing and sales costs, thereby raising the likelihood of entry.

The health insurance marketplaces were explicitly designed to facilitate competition among insurers. We also know that since the first open enrollment period began in October 2013 for consumer exchanges, millions of Americans who were previously uninsured now have access to affordable care. The Affordable Care Act has already expanded coverage, savings, and protections for millions of American consumers while promoting new competition.

The Department of Health and Human Services reported in July that the law had slowed the growth of health care premium costs as new competitors enter local markets and price competitions intensify. This report on competition in health insurance marketplaces also indicates that competition has intensified across the country, as the number of health insurance issuers have increased in the most counties since implementing the Affordable Care Act. Not only has this increased competition arrested the growth of health care premiums, the influx of new plans in local markets increases the pressure on incumbent insurance issuers to moderate the costs of premiums.

It is critical that we ensure that the number of new competitors in every market continues to grow, to drive down costs, and ensure that health care markets are delivering the best and most health care choices in every county and for every health care product in America.

I look forward to learning how the proposed transactions will achieve these vital policy objectives. With that, I yield back.

Mr. MARINO. Thank you.

The Chair now recognizes the full Judiciary Committee Ranking Member, Mr. Conyers of Michigan, for his opening statement.

Congressman?

Mr. CONYERS. Thank you, Mr. Chairman.

I want to welcome the witnesses, numerous but necessary for this important hearing, and I also welcome those concerned enough to attend this hearing about to take place.

We are talking about what we do with the second largest health insurance company and the fourth largest health insurance company, the third largest and the fifth largest. If consummated, these mergers will result in the number of large national health insurance companies going from five to three, leaving just UnitedHealthcare, Anthem, and Aetna.

Proponents of these mergers make a number of arguments in their favor, centering on the potential for efficiencies and enhanced consumer services these mergers are said to offer. Moreover, they contend that the lack of overlap between the merging firms in most

geographic markets means that there should be little risk to competition in allowing these mergers to proceed.

As we hear from the heads of the two acquiring firms as to why these mergers benefit competition and consumer welfare, however, we should keep in mind a few considerations. Begin with the two proposed mergers coming at a time when the health insurance markets seem to be already heavily concentrated. According to the 2015 study of competition in health insurance markets conducted by the American Medical Association, health insurance markets in seven out of 10 metropolitan statistical areas are already highly concentrated. In almost 40 percent of the metropolitan areas studied, one health insurer controls more than 50 percent of the market, as was the case in 14 States.

Moreover, according to the study by the Commonwealth Fund published last month, 97 percent of markets for Medicare Advantage, a program through which private insurers provide some Medicare benefit, are highly concentrated.

Prior instances of consolidation among health insurers led to increased premiums for consumers. In fact, there is no evidence that past health insurance mergers produced any savings that were passed on to consumers.

In addition, lack of competition among health insurers could diminish the quality of care that patients currently receive. In light of this broad concern about further consolidation in an already heavily concentrated industry, we have a duty to carefully examine some specific concerns that have been raised about these two proposed acquisitions.

For example, consumer groups fear that the Aetna-Humana transaction may result in a lessening of competition in Medicare Advantage markets. The combined Aetna-Humana would become the largest Medicare Advantage insurer with overlaps in a large number of geographic markets. Moreover, merger critics assert that neither traditional Medicare nor health plans offered by providers are meaningful substitutes for Medicare Advantage plans, meaning that the potential for competitive harm in Medicare Advantage markets is great.

Now with respect to the Anthem-Cigna merger, the American Hospital Association in particular notes that Anthem's affiliation with the Blue Cross and Blue Shield system may raise competitive concerns, in the event the merger is consummated. The association asserts that the merger could further entrench the already dominant position that many Blue Cross Blue Shield plans have in many States.

Also, there may be a national market for health insurance for large employers. Reducing the number of national competitors from five to three would undermine competition in that market.

Finally, we must address the issue of whether divestitures are a sufficient remedy for the anticompetitive effects of these mergers. Because of the high barriers to entry into the health insurance business, critics contend, competition is unlikely to be restored once lost through consolidation.

So I hope that all of our distinguished witnesses will take this opportunity to address these and other concerns they may have.

Accordingly, I look forward eagerly to their testimony and thank them for appearing today.

Thank you, Mr. Chairman.

Mr. MARINO. Thank you.

Mr. JOHNSON. Mr. Chairman, I would ask that a letter from U.S. PIRG and a statement from Consumers Union be entered into the record, without objection.

Mr. MARINO. So granted.

[The information referred to follows:]



September 21, 2015

Chairman Michael S. Lee
Senate Judiciary Subcommittee on Antitrust, Competition Policy, and Consumer Rights
224 Dirksen Senate Office Building
Washington, D.C. 20510

Re: The Anthem/Cigna and Aetna/Humana Mergers

Dear Chairman Lee:

The undersigned consumer groups and unions have long been concerned with the competitive landscape within healthcare markets. As has been well-documented, our current fragmented, fee-for-service based healthcare system is broken. In order to improve healthcare, we must create competitive health markets that provide ample choice, high quality, and transparency. Through both private innovation and with the passage of the Affordable Care Act, there are now documented improvements in healthcare and increased access to needy patient populations. The industry is also shifting Medicare to value-based payments and lowering the growth rate of premiums.

We write to raise our serious concerns with the proposed consolidation in the health insurance market.¹ As detailed below the proposed mergers between Anthem and Cigna and Aetna and Humana raise will reduce the number of major health insurers from 5-3 and will pose the threat of substantial harm to millions of consumers.^{2,3} We applaud this Committee's review of these mergers and hope its scrutiny will clarify the serious competitive concerns of these mergers.

¹ See, e.g., David Balto & James Kovacs, *Health Insurance Merger Frenzy: Why DOJ Must Just Say 'No'*, LAW360 (Aug. 17, 2015, 5:59 PM), <http://goo.gl/OEEcQF>.

² Steve Sternberg, *Health Insurer Mergers Signify Shift in Health Care Marketplace*, US NEWS (Aug. 21, 2015, 1:23 AM), <http://goo.gl/4G9OrK>.

³ While this letter discusses the competitive impact of the mergers, the Subcommittee should also consider the impact of the Blue Cross and Blue Shield Association. Anthem is a "Blue" mark holder and therefore is bound by the rules of the association including ensuring that two-thirds of their annual revenue must be attributed to the Blue mark. If Anthem acquires Cigna, the combination may prevent the newly merged firm from expanding non-Blue business and may also require Cigna to pull out of markets in which another Blue insurer competes. See Jacqueline DiChiara, *BCBS Licensing Agreement Questioned in Anthem Acquisition*, REVCYLCEINTELLIGENCE (Aug. 26, 2015), <http://goo.gl/NRHoy8>.

Growing consolidation within health insurance could reverse many of the gains in healthcare innovation. Over 72 percent of all health insurance markets are highly concentrated.⁴ In small group insurance markets, for example, the average market share of the largest insurer is 57 percent, with Alabama, the District of Columbia, Louisiana, Mississippi, North Dakota having dominant insurers with a greater than 80 percent share.⁵ Indeed, these high levels of concentration were part of the reason why legislation was necessary to bring transparency and competition to these markets.

Merging four of the major insurers, the only insurers with national scope, raise very serious competitive concerns. According to the American Medical Association, the mergers would further cause competitive harm by eliminating competition in 126 metropolitan statistical areas (“MSA”) and nearly two dozen states.⁶ As your Committee questions the parties in the September 22 hearing, the signors of this letter offer a list of potential issues that should be addressed.

What will the Impact of the Mergers be on Premiums and Innovation?

Consumers are concerned that the market power achieved post-mergers will allow both Aetna and Anthem to raise costs on consumers while simultaneously eliminating innovation. According to one health economics expert at the University of Southern California’s Schaeffer Center for Health Policy and Economics, “when insurers merge, there’s almost always an increase in premiums.”⁷ There is little dispute that there is a direct correlation between insurance concentration and higher premiums.⁸ In fact, evidence shows that a state’s largest insurance company can increase its rates 75 percent higher than smaller insurers within the same state.⁹

Predicting the potential competitive impact of a merger can be challenging. However, in this case the “past is prologue.” Economic studies of consummated health insurance mergers demonstrate a simple truth—mergers lead to premium increases and higher costs to consumers.¹⁰ The two retrospectives on health insurance merger matters have both found significant premium increases post-merger.¹¹ There are no economic studies to the contrary.

⁴ See David W. Emmons & Jose R. Guardado, *Competition In Health Insurance: A Comprehensive Study of U.S. Markets*, AM. MED. ASSOC. (2014).

⁵ *Small Group Insurance Market Competition*, KAISER FAMILY FOUNDATION (2014), <http://goo.gl/Uyy05J>.

⁶ *States where health insurers are squeezing out competition*, AM. MED. ASSOC. (Sept. 8, 2015, 6:00 AM), <http://goo.gl/wUp33>.

⁷ David Lazarus, *As Health insurers merge, consumers’ premiums are likely to rise*, L.A. TIMES (July 10, 2015 4:00 AM), <http://goo.gl/nF7HRS>.

⁸ Leemore Dafny, *Are Health Insurances Markets Competitive?*, 100 AM. ECON. REV. 1399 (2010).

⁹ Eugene Wang and Grace Gee, *Larger Insurers, Larger Premium Increases: Health insurance issuer competition post-ACA*, TECH. SCI. (Aug. 11, 2015), available at <http://goo.gl/918UJo>.

¹⁰ The DOJ has challenged a health insurance merger on the theory that the merger would have resulted in higher prices, fewer choices, and reduction in quality. See Press Release, *Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans*, DOJ (March 8, 2010), <http://goo.gl/CWpd90>.

¹¹ See Leemore Dafny et al., *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, 102 AM. ECON. REV. 1161 (2012); see also Jose Guardado et al. *The Price Effects of a Large Merger of Health Insurers: A Case Study of United-Sierra*, 1(3) HEALTH MANAGEMENT, POL’Y & INNOVATION 1 (2013).

Proponents of the mergers may suggest that size matters and they can achieve greater efficiencies from the mergers. The antitrust laws permit efficiencies to be considered only if they will: (1) outweigh the competitive harm, (2) result in benefits to consumers in lower prices or better service and (3) there is no less anticompetitive means to achieve the same efficiencies. The Committee should ask whether these mergers can meet these standards. In any case, again the past makes us cautious about these claims. There is no evidence that past health insurance mergers produced significant efficiencies that benefitted consumers.

The insurers might argue they will secure greater buying power (“monopsony power”), and this will enable them to lower reimbursement rates to dominant providers and pass these savings along to consumers.¹² There are no studies nor evidence that this increased power has led to lower premiums. As noted by Thomas Greaney, a leading health antitrust scholar, there is actually “little incentive [for an insurer] to pass along the savings to its policyholders.”¹³

Regulation alone will not protect consumers from competitive harm. Any argument regarding regulatory structure controlling an insurer’s ability to raise premium prices, including medical loss ratio (“MLR”) and rate review, is inaccurate. While MLR ensures that insurers must spend between 80 to 85 percent of net premiums on medical services and quality improvements, it does not act as a “price cap.” In response to MLR provisions, insurers can always raise premiums to ensure higher profits. Furthermore, rate review cannot prevent health insurance companies from raising premiums above competitive levels. While some states have their own form of rate review, rate review at the federal level does not apply to grandfathered insurance plans or to large group health plans.¹⁴ Additionally, while the Department of Health and Human Services may state that a rate increase is unreasonable and unjustified, the Department has no authority to reject the rate increase.¹⁵

The parties may suggest the mergers may lead to greater innovation. This is a very important issue since health care markets need a spur in innovation to move to a patient-oriented system delivering higher quality, lower cost care. The movement from volume-based to value-based healthcare has created incentives for insurers and providers to institute new payment policies that incentivize improving care and lowering costs. However, these mergers will create new, dominant entities, and the loss of competition will reduce the need to collaborate with hospitals and healthcare providers “to initiate development of new products.”¹⁶ When examining these mergers, industry experts have suggested that the mergers could “undercut” innovation efforts.¹⁷ Such a loss in innovation would harm consumers as insurers compete less with providers to offer new insurance products.

¹² See Victoria R. Fuchs and Peter V. Lee, *A Health Side of Insurer Mega-Mergers*, WALL ST. J. (Aug. 26, 2015, 6:36 PM), <http://goo.gl/hMhuzl>.

¹³ See Thomas Greaney, *Examining Implications of Health Insurance Mergers*, HEALTH AFFS. (July 16, 2015), <http://goo.gl/ETTIDB>.

¹⁴ *Rate Review*, DEPT. OF HEALTH AND HUMAN SERVICES, <http://goo.gl/ZdEh8h> (last visited Sept. 20, 2015).

¹⁵ Amanda Cassidy, *‘Unreasonable’ Insurance Rate Increases*, HEALTH AFFS. (Mar. 21, 2011), <http://goo.gl/BYyAM>.

¹⁶ *Horizontal Merger Guidelines*, DEP’T OF JUSTICE AND FED. TRADE COMM’N at § 6.4 (2010), available at <https://goo.gl/YXo32O>.

¹⁷ See Reed Abelson, *With Merging of Insurers, Questions for Patients About Costs and Innovation*, N.Y. TIMES (July 5, 2015), <http://goo.gl/NPp38y>.

What is the Effect of Increased Monopsony Power?

It is indisputable that dominant insurers have monopsony power, also known as buying power, obtained through their large enrollment numbers. Monopsony power allows insurers to have favorable negotiations with healthcare providers including large hospital systems, small physicians' practices, and rural hospitals and solo practitioners. While the ability to drive down reimbursement can be competitive in certain situations, monopsony power can also lead to anticompetitive effects.

Monopsony power also creates incentives for powerful insurers to limit consumer options and access to providers. Again, limited or tiered networks can be used to control health care costs. But, when a single insurer has significant market power, it can utilize a restricted network to limit consumer access to needed care. This issue is compounded by the growing shortage of physicians, and weak or non-existent health insurance network adequacy protections in many states.¹⁸

What is the Impact on Competition in Health Insurance Exchanges?

The newly formed health insurance markets, both federal and state-run, have been widely successful in allowing consumers to comparison shop for health insurance plans offered by numerous competitors. According to research by the Kaiser Family Foundation, on average, a consumer shopping on an exchange has access to a range of products offered from by six different insurance companies.¹⁹ As a result of this competition and transparency, 10.2 million consumers have purchased affordable insurance on the exchanges.²⁰

While the exchanges have been successful, the mergers could drive down competition on the exchanges in a number of markets. All four of these insurance companies compete on the exchanges, with overlaps in a number of states.²¹ Prior to the announced mergers, these insurers were considering further expanding their footprint on the exchanges by entering a number of new states.²² The Clayton Act protects not only existing competition but also potential competition. (Indeed, protecting potential competition was the basis for the Pennsylvania Insurance Commissioner's successful challenge of the Highmark-Independence Blue Cross merger).²³

¹⁸ See Peter D. Jacobson & Shelley A. Jazowski, *Physicians, the Affordable Care Act, and Primary Care: Disruptive Change or Business as Usual*, 26(8) J. GEN. INTERNAL MED. 934, 95 (2011) ("While imbalances in supply and demand characterize the physician shortage, other confounding factors, include[e] inadequate primary care reimbursement rates").

¹⁹ *Number of Issuers Participating in the Individual Health Insurance Marketplaces*, KAISER FAMILY FOUNDATION (2015), <http://goo.gl/8KlmtA>.

²⁰ Press Release, U.S. Dep't of Health and Human Services, March Effectuated Enrollment Consistent with Department's 2015 Goal (June 2, 2015), available at <http://goo.gl/4tPGxO>

²¹ See *Health Insurance Exchanges or Marketplaces: State Profiles and Actions*, NAT'L CONFERENCE OF STATE LEGISLATURES, <http://goo.gl/JMYAgN> (last visited Sept. 8, 2015).

²² See Bruce Japsen, *With Insurer ACA Expansions In 2015, More Obamacare Choices, Competition*, FORBES (Aug. 3, 2014), <http://goo.gl/YQe4b4>.

²³ See Shakeba DuBose, Jayne E. Juvan, & Frank Stevens, *Highmark and Independence Blue Cross Part Ways—Pennsylvania Regulatory Hurdles Thwart Attempted Consolidation*, AM. HEALTH LAWYERS ASS'N (April 2010), <http://goo.gl/sUfK0c>. See also Testimony of David A. Balto, *Consolidation in The Pennsylvania Health Insurance*

Losing competition between these plans on the exchanges will most certainly raise rates for consumers.

To the degree the mergers enable these firms to secure lower reimbursement, they may distort competition on the exchanges. If an insurer forces down reimbursement from, for example, a hospital, that hospital may be forced to increase its reimbursement from other insurers. This is known as the “waterbed effect.”²⁴ Those demands for increased reimbursement will put the smaller insurers and new entrants in the exchanges at a competitive disadvantage harming overall competition on the exchanges.

As an example of how losing an insurer can impact an exchange market, in 2014, Minnesota’s PreferredOne, a dominant insurer on the MNsure exchange with the lowest rates, pulled out of the exchange for 2015.²⁵ Since PreferredOne’s departure, there has been no new entry into the MNsure exchange, and the remaining insurers have sought a proposed premium rate increase of 35 percent.²⁶ Losing both Cigna and Humana on the exchanges could have a similar effect on a number of exchanges throughout the United States.

The Potential Loss of Competition in Medicare Products

Private Medicare Advantage and Part D prescription plans are two of the fastest growing health insurance market segments. These “Medicare alternatives” for elderly consumers play a vital role in offering expanded services from traditional Medicare. In Medicare Advantage, there are now 16.8 million beneficiaries enrolled in 1,945 plans.²⁷ In Medicare Part D, there are over 37 million beneficiaries, two-thirds of which are in standalone prescription drug plans and one-third in Medicare Advantage prescription drug plans.²⁸

Much like other health insurance markets, Medicare markets are highly concentrated. A recent Commonwealth Fund study found that 97 percent of all Medicare Advantage markets are highly concentrated. Available data in Medicare Part D markets shows six dominant insurers, including Humana (16 percent), Aetna (6 percent), and Cigna (5 percent) market share nationally.²⁹

Industry: The Right Prescription?, Hearing Before the Senate Judiciary Committee, Subcommittee on Antitrust, Competition Policy and Consumer Rights, available at <http://goo.gl/DrcAKk>.

²⁴ See John B. Kirkwood, *Powerful Buyers and Merger Enforcement*, 92 B.U. L. REV. 1485, 1544-46 (2012) (“But it does draw support from the ‘cost shifting’ that has occurred in the health care industry. While the evidence is not uniform and the shifting is often not complete, a number of studies have concluded that hospitals, both for-profit and not-for-profit, have reacted to lower Medicare or Medicaid payments by increasing the charges they levy on private payers.”)

²⁵ Katie Bo Williams, *Dominant insurer to pull out of MN exchange*, HEALTHCARE.DIVE (Sept. 16, 2014), <http://goo.gl/vtAfCw>.

²⁶ Louise Norris, *Minnesota health insurance exchange / marketplace*, HEALTHINSURANCE.ORG (July 28, 2015), <http://goo.gl/YuUKcG>.

²⁷ *Medicare Advantage: Total Enrollment*, KAISER FAMILY FOUNDATION, <http://goo.gl/AUwdKe>.

²⁸ *The Medicare Prescription Drug Benefit Fact Sheet*, KAISER FAMILY FOUNDATION (Sept. 19, 2014), <http://goo.gl/plqrGl>.

²⁹ Jack Hoadley et al., *Section 1: Part D Enrollment and Plan Availability*, KAISER FAMILY FOUNDATION (Aug. 18, 2014), <http://goo.gl/ZYULwL>.

All four insurers compete in both Medicare Advantage and Part D. A combination of these insurers would eliminate competition for millions of consumers nationwide. In particular, the combination of Aetna and Humana would create the predominant Medicare Advantage insurer with anticompetitive overlaps in a large number of MSAs.³⁰

The lessening of competition will not only raise costs to consumers but also limit benefits and performance of plans. As noted in the Division's 2012 complaint in Humana's acquisition of Arcadian Management Services, a large Medicare Advantage insurer, Medicare Advantage insurers "compete for enrollment by lowering costs, lowering premiums, increasing benefits, and improving performance."³¹ Therefore, a loss of competition would eliminate a number of consumer benefits including more benefits, expanded drug coverage, and larger provider networks.³²

Can Remedies Cure the Loss of Competition?

The parties may suggest that any competitive problems can be resolved through simple divestitures of subscribers. In nearly every insurance matter for over the last decade, the Division has exclusively relied on this type of structural remedy.³³

However, the antitrust agencies are becoming increasingly skeptical about whether divestitures can effectively restore competition and for good reason. Economic studies increasingly are demonstrating that divestitures, even of a significant nature, do not always adequately restore competition. An economic survey by Professor John Kwoka finds that divestitures often fail to fully restore competition.³⁴ Indeed that skepticism has led the DOJ, FTC and the courts to reject divestitures in other merger matters. In their reviews of the proposed mergers of Comcast-Time Warner Cable and Sysco-US Foods, the enforcement agencies rejected the parties requested divestitures in both matters and instead blocked the mergers (and in Sysco the court agreed with the FTC decision and enjoined the merger).³⁵

³⁰ Letter from Melinda Hatton, Senior Vice President and General Counsel, American Hospital Association, to William Baer, Assistant Attorney General, Department of Justice Antitrust Division (Sept. 1, 2015), available at <http://goo.gl/S3gZCt>.

³¹ Complaint, *United States v. Humana Inc.*, No. 1:12-cv-00464 (D.D.C. March 27, 2012).

³² *Id.* at 9.

³³ See Revised Final Judgment, *United States v. Aetna Inc. and Prudential Insurance Co. of Am.*, No. 3-99CV 1398-H (N.D. Tex. Dec. 7, 1999); see also Final Judgment, *United States v. UnitedHealth Group Inc. and Sierra Health Servs. Inc.*, 1:08-CV-00322 (D.D.C. Sept. 24, 2008); see also Final Judgment, *United States v. Humana Inc.*, No. 1:12-cv-00464 (D.D.C. March 27, 2012).

³⁴ John Kwoka, *MERGERS, MERGER CONTROL, AND REMEDIES: A RETROSPECTIVE ANALYSIS OF U.S. POLICY*, MIT PRESS (2015).

³⁵ Press Release, DOJ, Comcast Corporation Abandons Proposed Acquisition of Time Warner Cable After Justice Department and Federal Communications Commissions Informed Parties of Concerns (Apr. 24, 2015), available at <http://goo.gl/msZq6f>; see also Press Release, FTC, Following Sysco's Abandonment of Proposed Merger with US Foods, FTC Closes Case (July 1, 2015), <https://goo.gl/XfwPsW>.

These mergers raise a very serious question – can any divestiture fully restore competition. As consumer groups noted in a recent generic drug merger it may be extremely difficult to structure and effectuate a merger involving dozens of markets.³⁶

Studies also show that divestitures in health insurance matters do not alleviate the transaction's overall competitive impact. In the 1999 merger between Aetna and Prudential, the Division required Aetna divest its health maintenance organization lines in Texas.³⁷ Despite the divestitures, a study analyzing 139 separate geographic markets found that increases in market concentration from 1998 to 2006 raised premiums by roughly seven percent.³⁸ Another study found that the 2008 merger between UnitedHealth and Sierra Health Services and subsequent divestitures of the plans' Medicare Advantage business in Las Vegas did not prevent the United from increasing premiums by 13.7 percent.³⁹

Lastly, divestitures in these matters may be nigh impossible in a number of markets. In examining the Anthem and Cigna merger, the American Hospital Association found that of the 817 at-risk markets post-merger, 368 MSAs do not have an insurance competitor that can effectively compete and "preserve the pre-merger market structure."⁴⁰ All of the divestitures in earlier health insurance mergers were phenomenally smaller. There are strong reasons to doubt the ability to structure a remedy to fully restore competition in these mergers where the overlaps are far more substantial.

Conclusion

For the forgoing reasons, the undersigned groups urge the Subcommittee to undertake a thorough investigation into the issues raised in the letter and by other commentators concerning the Anthem and Cigna and Aetna and Humana mergers. Given the current consolidated nature of healthcare system, the past-evidence of harm from prior insurance mergers, and the market overlaps in this matter, we believe the parties should provide answers and analysis on why these mergers would not substantially lessen competition in violation of the antitrust laws.

Please do not hesitate to contact us with any questions.

Respectfully submitted,

Consumer Federation of America
U.S. Public Interest Research Group
Alliance for a Just Society
Consumer Action
CT Citizen Action Group

³⁶ Letter from Consumers Union et al., to Edith Ramirez, Chairwoman FTC (July 14, 2015), *available at* <http://goo.gl/5glEAdK> (discussing Teva's hostile takeover of Mylan that was later dropped by Teva).

³⁷ See Revised Final Judgment, *Aetna Inc.*, No. 3-99CV 1398-H.

³⁸ Dafny, *supra* note 10 at 1163.

³⁹ Guardado, *supra* note 10 at 21.

⁴⁰ Letter from Melinda Halton, Senior Vice President and General Counsel, American Hospital Association, to William Baer, Assistant Attorney General, Department of Justice Antitrust Division (Aug. 5, 2015), *available at* <http://goo.gl/S3gZCt>.

DC-37
Main Street Alliance
Sergeants Benevolent Association
Virginia Rural Health Association



**STATEMENT FOR HEARING RECORD
GEORGE SLOVER
SENIOR POLICY COUNSEL
CONSUMERS UNION**

BEFORE THE

**SUBCOMMITTEE ON REGULATORY REFORM,
COMMERCIAL AND ANTITRUST LAW
HOUSE COMMITTEE ON THE JUDICIARY**

ON

**HEALTHY COMPETITION? AN EXAMINATION OF THE
PROPOSED HEALTH INSURANCE MERGERS AND THE
CONSEQUENT IMPACT ON COMPETITION**

September 29, 2015

Chairman Marino, Ranking Member Johnson, and Members of the Subcommittee: Consumers Union, the public policy arm of Consumer Reports, commends the Subcommittee for holding this important hearing on concentration in the health insurance marketplace, and we appreciate the opportunity to submit our views.

Our mission is to work for a fair, just, and safe marketplace for all consumers, and to empower consumers to protect themselves. And one key to empowering consumers to protect themselves is working to ensure meaningful consumer choice, through effective competition.

By meaningful choice, we mean easy for consumers to understand and compare, and sensitive to what's important to consumers. When consumers have meaningful choice, businesses are stimulated to provide more affordability, better quality, and new thinking.

From our founding almost 80 years ago, one of our top priorities has been to make health care available and affordable for all Americans. We are actively engaged at the federal and state level in working for policies to better ensure that consumers' health care and health insurance options are understandable and affordable, and in educating consumers. As part of these efforts, we've recently launched the Health Care Value Hub website, a networking and resource center for consumer advocates and others working to improve health care value for consumers.

The health care marketplace is complex in how it operates and how it motivates providers, insurers, and consumers. And a regulatory framework has developed over many years – and is still evolving – to work within and shape that complex environment, and help safeguard consumers, help keep costs under control, and help make a full range of health care services available. A century or more of experience shows you can't run the health care system on competition alone and just allow the free market to go where it will.

For example, we needed to legally prohibit insurance companies from lowering their costs by denying coverage for pre-existing conditions. This is a key consumer protection that the free market had shown it was unlikely to take care of on its own.

Another example is setting minimum coverage requirements for health insurance policies sold on the new exchanges. In these and numerous other ways, regulation can promote improved health care delivery and improved cost control.

But while our regulatory framework sets important minimum coverage and other requirements and safeguards, and it standardizes plan and benefit descriptions for easier comparison, consumers benefit from also having effective competition, at all levels in the supply chain. Even the best regulatory framework works better where competition, within appropriate regulatory limits, gives businesses an additional incentive to want to improve service while holding down prices and providing better value.

Regulation and competition both work best when they work hand in hand.

Some collaboration, coordination, and even consolidation can be good for consumers, and consistent with effective competition, when the result is to make it easier to provide service more efficiently and affordably – and when those benefits actually reach consumers. One very basic example is a group doctor practice that allows doctors to better serve more patients by ensuring patients are covered 24-7 even when their main doctor can't be reached.

Our regulatory framework accommodates, even encourages various forms of collaboration and integration for more effective delivery of health care and more effective cost control. And within limits, these can be beneficial to the overall functioning of the health care system, and beneficial to consumers.

But when there's too much concentration, among hospitals, or doctors, or insurers, it can undermine the overall functioning of the system, and harm consumers. Dominant players can start dictating to others, closing off choices consumers want, increasing the prices consumers pay, and impairing the quality of what consumers receive.

Health insurers play a key role in helping make the health care system work for consumers. We see that every time we look at a medical bill and read the markdown

for the disallowed portion – the difference between what the provider would like to charge us, and what it is willing to accept to be part of our health care plan’s network.

But a dominant insurer could force doctors and hospitals to go beyond trimming costs, to cut costs so far that it begins to degrade the care and service they provide below what consumers value and need. Competition, at all levels, helps keep incentives to control costs from being misdirected into degrading quality of care and service.

As the Justice Department has explained, where there is effective competition, insurers compete against each other by offering plans with lower premiums, reducing copayments, lowering or 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.¹

We want those motivations to stay strong. Providing all these benefits costs the insurance plans more than not providing them. What makes it in their interest to provide them all anyway is that doing so attracts customers who might otherwise go elsewhere. For that to work, there needs to be an elsewhere for customers realistically to go.

There is ample evidence that high market concentration among sellers of health insurance, like high market concentration among sellers of hospital or medical services – or of any other product or service, for that matter – leads to increased costs for consumers, and more broadly, to less value. Health care markets, for all their complexities and special characteristics, are no exception to this fundamental experience.

It is with all this in mind that we look at concentration in health insurance, and the proposed Aetna/Humana and Anthem/Cigna mergers. The Justice Department’s investigations are just getting underway. But there are strong indicators, to us, that

¹Competitive Impact Statement, *United States v. Humana*, *United States v. Humana Inc. and Arcadian Management Services, Inc.*, No. 12-cv-464 (D.D.C., March 27, 2012), at 8, available at www.justice.gov/atr/case/us-v-humana-inc-and-arcadian-management-services-inc.

these mergers could create too much concentration, in too many markets, and cause too much harm to consumer choice.

There would be large increases in concentration in many of the local markets where health care services are provided and paid for. These markets are not just defined by geographic area. There are submarkets in each local area, different kinds of insurance coverage where competition won't cross over much if at all. For example, seniors aren't going to give up their Medicare Advantage policy and switch over to an individual policy on the state health insurance exchange. Each of these submarkets – individual, small employer, associational, large employer, Administrative Services Only, Medicare Advantage, etc. – will need to be examined separately and carefully.

It's important to look not just at a snapshot of where competition is happening now in each of those submarkets, and what current competition would be immediately eliminated, but also to look over the next hill, at what these mergers mean for future competition. A consummated merger can't be easily unwound to restore lost competition.

These four insurance companies all offer health insurance in a wide range of markets throughout the country, in various degrees of direct competition with each other. They all participate to a greater or lesser extent in the state exchanges. And they are in prime position to expand on their own into other state exchanges, and other markets. After all, they not only have the expertise and experience; they also have the financial resources to more easily get through the start-up period of building relationships with providers, and marketing to consumers.

These are the chicken-and-egg building blocks of starting up that create the biggest barriers to entry. You need good provider networks to attract consumers, and you need a large pool of consumers to attract providers.

Taking the longer view is also important because, if the Justice Department were to stand by and allow concentration to increase right up to the very brink of obvious and immediate harm, there's no margin for error, or for all-too-foreseeable developments beyond the control of the antitrust laws or anyone else. What if one of

the current key players later decides to downsize or close shop? The antitrust laws don't force someone to work, and they don't force a company to stay in business.

The antitrust laws, and the Justice Department's own Merger Guidelines, recognize the importance of taking potential competition and market uncertainties into account. And the Clayton Act itself is written to prohibit mergers that "may" substantially lessen competition, or "tend to" create a monopoly. That gives the Justice Department plenty of latitude for taking the longer view – and we believe that's particularly important here.

It's also important to be skeptical of claims that the prospect of new market entry by unspecified others takes care of the concerns. If these four insurance giants are seeking the merger short-cut to expansion, because they've decided that expanding on their own is not as convenient for them, not worth the trouble, how can we be confident that expansion by other, smaller, or even nonexistent insurance companies is going to be there to effectively hold the market power of the giants in check?

And it's also important to be skeptical of claims that the problems with these mergers can be solved by having the merging insurance companies spin off, or divest, some of the operations in markets where they currently compete against each other. First of all, in these two cases, it looks like there are just too many markets and submarkets affected, especially if you include – as you should – markets and submarkets where these companies haven't entered yet but are in a good position to.

Second, divestitures don't always work. Empirical studies and experience indicate that many divestiture remedies have not lived up to their promise. The promise is that there's this other company standing ready to take over the operation, with the same commitment and the same capability to give the same level of competition, now and into the future. That's always going to be a roll of the dice. After all, if this new company is really so capable and committed, why isn't it in the market already? Even under the best of circumstances, there's no guarantee that the new company taking over will stay committed, and actually prove to have the capability, to compete over the long haul. Often, it doesn't.

One justification we've heard for approving these mergers is that giving these insurance companies more market power will offset the market power of hospitals and doctor groups. We are certainly aware of, and concerned about, increased concentration that has been taking place in provider markets – and how it can lead to less choice for consumers, and higher premiums and costs, and less value.

But the solution to too much provider market power is not to give health insurers their own market power and then hope they'll take care of us. This has come to be referred to in antitrust circles as the “sumo wrestler theory” – that somehow adding market power at one level of the supply chain “stands up to” and offsets market power at another level.

But the actual result is just more market power, with more of all the harmful effects that flow from it. The two sumo wrestlers typically end up deciding to shake hands – that is, they find an accommodation that benefits them both – and they go after everybody else. And the everybody else, those who don't have market power – and that includes consumers with a ring-side seat, as well as smaller hospitals, local clinics, and medical practices – get tossed around, sat on, sometimes mercilessly crushed.

We want doctors, hospitals, and clinics to be motivated to look for ways to lower rates without cutting corners on quality of care and other aspects of service that consumers value. That's the difference between providers wanting to trim costs to compete, versus being forced to cut service to the bone in hopes to survive. It's the difference between responding to incentives that flow from competition, versus knuckling under to a market dictator.

Taking aggressive enforcement action to stop the creation, augmentation, or further entrenchment of this kind of insurance market power is entirely consistent with recognizing that an insurer of a certain size can often better attract more willingness from providers to accept lower rates, because the insurer offers network access to enough patients to make it worthwhile. But these four insurance giants would seem to be already well past that threshold. And in specific local markets where they aren't at that size yet, you would think they could get there by expanding

on their own – that they wouldn't need to join forces with their most able competitors.

And again, being of a size and reach to offer that advantage, to attract providers and consumers, is different from having the power to make them an offer they can't refuse. One contributes to consumer choice; the other snuffs it out.

It is perhaps understandable that some health insurers, in reacting to the new challenges and opportunities in the evolving health care marketplace, would seek to gain more leverage, to ease their way to meeting those challenges and taking advantage of those opportunities, by merging to increase their market power. But while they may see that as in their interest, that doesn't mean it's in consumers' interest.

Competition at the insurance level will help ensure that the business interests of health insurers in their dealings with providers, large and small, are more closely aligned with the interests of consumers.

If the anticompetitive merger route is cut off, we would hope to see those profit-seeking energies redirected to expanding into underserved markets, and to improving quality, safety, and customer service. All of these will improve meaningful choice for more consumers – and ultimately, will improve consumer health, and the health of our pocketbooks.

The Justice Department's investigations are just getting underway. There are a lot of market details to examine. And we are not here to prejudge the outcome of these investigations. But we want both investigations to be thorough. At this point, we have a hard time seeing how these mergers could pass muster under the Clayton Act. And the stakes for consumers are high. If somehow these mergers do get a pass, or if either of them does, we'll want the Justice Department to explain why.

Thank you again for the opportunity to present our views on this important issue for consumers.

Mr. JOHNSON. Thank you.

Mr. MARINO. The Chair now recognizes the Chairman of the full Judiciary Committee, Mr. Bob Goodlatte of Virginia, for his opening statement.

Mr. GOODLATTE. Thank you, Mr. Chairman.

Mr. Chairman, this past July, Aetna announced its intent to merge with Humana, and Anthem similarly proposed to merge with Cigna. These firms represent four of the five largest for-profit health insurance companies in the country.

Currently, the Department of Justice is reviewing the deals. Its review will involve a detailed, fact-specific analysis that will likely take more than a year to complete. Unless the Department of Justice seeks to enjoin one or both of the transactions, nearly the entire antitrust review process will take place outside the public view.

In contrast, today we have before us the two CEOs of the acquiring companies who will state their cases for the mergers. They sit at the same table as some of the most vocal critics of the deals, and each will have an opportunity to respond to our questions about their views and the impacts of the prospective transactions. Through this record, the public will better understand the asserted merits and concerns regarding the proposed mergers. Furthermore, the record created today will assist the Committee in administering its oversight of the antitrust enforcement agencies.

Lurking behind the antitrust review of these deals is the question of how much influence Obamacare had on the proposed transactions. This issue is of keen interest to the Committee and we have conducted several hearings on the broader issue of Obamacare and its impacts on consolidation and competition in the health care industry.

Certainly, the Affordable Care Act has had a profound effect on the health insurance industry. The law greatly diminished the flexibility of insurance companies to manage the risks of insuring patients. Coupled with these rigid parameters are requirements on how insurance companies can allocate funds for medical claims and other expenses. In many respects, health insurance under the Affordable Care Act resembles more of a commodity than the nuanced and diverse product base that existed prior to the law's enactment.

Many commentators speculated that these constraints, together with the significant regulatory burden placed on insurers, would cause greater consolidation in the industry. The Affordable Care Act put into place incentives for insurers to increase in size so they can better manage costs and the heavy regulatory burden and operational constraints imposed by the law.

Indeed, at our most recent hearing focused on consolidation in the health care industry, we heard testimony that insurers are leaving the market, insurance policy coverage is narrowing, and consumers are ending up paying more for less. These are hardly the results that Obamacare proponents promised.

In addition to learning about the specifics of the proposed mergers and the concerns raised by critics of the deals, I look forward to hearing about the role the Affordable Care Act played in these mergers and in the insurance market generally.

Thank you, Mr. Chairman, for continuing the Committee's series of hearings on competition in the health care industry. I look forward to today's discussion on the pending health insurance mergers, and I yield back.

Mr. MARINO. Thank you, Chairman.

Without objection, other Members' opening statements will be made part of the record.

I will begin by swearing in our witnesses before introducing them.

Would you please stand and raise your right hand?

Do you swear or affirm that the testimony you are about to give before this Committee is the truth, the whole truth, and nothing but the truth, so help you God?

Let the record reflect that the witnesses have responded in the affirmative.

Please be seated, and thank you.

I am now going to introduce all the witnesses. I will go through each of your bios, and then we will get back to your opening statements. If I mispronounce your name, please correct me.

I think I can get this one right. Mr. Bertolini is the chairman and chief executive officer of Aetna. Mr. Bertolini joined Aetna in 2003 and served as the company's president from 2007 until 2014. Prior to joining Aetna, Mr. Bertolini held executive positions at Cigna, and NYLCare Health Plans, and SelectCare, Inc. He earned his undergraduate degree in business administration and finance from Wayne State University and an MBA in finance from Cornell University.

Welcome, sir.

Mr. Swedish is the president and chief executive officer of Anthem. Mr. Swedish has served for more than 40 years in leadership positions within the health care industry, including 25 years as a CEO for major health systems. Mr. Swedish earned his bachelor's degree from the University of North Carolina at Charlotte and his master's degree in health administration from Duke University.

Welcome, sir.

Mr. Nickels recently became the executive vice president of government relations and public policy at the American Hospital Association (AHA). He has been with the AHA for over 21 years, recently serving as the association's senior vice president for Federal relations. Mr. Nickels earned his bachelor's degree in English and philosophy from Dickinson College and his J.D. from New York University School of Law.

Welcome, sir.

Dr. Gurman is the president-elect of the American Medical Association. He is an orthopedic hand surgeon from Altoona, Pennsylvania.

Welcome, sir, from one Pennsylvanian to another.

Previously, he served as speaker and vice speaker of the AMA House of Delegates for 8 years. Dr. Gurman earned his bachelor's degree from Syracuse University and his medical degree from the State University of New York.

Professor King is a professor of law and the associate dean and co director of the University of California, San Francisco, and the University of California, Hastings Consortium of Science, Law and

Health Policy. Professor King's work has been published in numerous scholarly journals, including the UCLA Law Review, the Yale Journal of Health Policy, Law and Ethics, and the American Journal of Law and Medicine, among others. Professor King received her bachelor's degree, cum laude, from Dartmouth, her J.D., cum laude, and Order of the Coif, from Emory University, and her Ph.D. in health policy from Harvard University.

Welcome.

Mr. Haislmaier is a senior research fellow of health policy studies at the Heritage Foundation. He is widely considered an expert on health care policy, an industry he has been studying since 1987, and frequently testifies between State and Federal legislative committees. Mr. Haislmaier earned his bachelor's degree in history from St. Mary's College in Maryland.

Welcome.

Each of the witnesses' written statements will be entered into the record in its entirety. I ask that each witness summarize his or her testimony in 5 minutes or less. To help you with that, there is a timing light in front of you, and the light will switch from green to yellow, indicating that you have 1 minute to conclude your testimony. When the light turns red, it indicates that your 5 minutes have expired. As I do this just customarily, because I know you are concentrating on giving your statement, I will politely, nonchalantly, raise the gavel, to give you a little indication to please wrap up, before slamming it down.

Mr. Bertolini, please?

**TESTIMONY OF MARK T. BERTOLINI, CHAIRMAN AND
CHIEF EXECUTIVE OFFICER, AETNA, INC.**

Mr. BERTOLINI. Good afternoon, Chairman Marino, Ranking Member Johnson, other Members of the Committee. Thank you for inviting me here today to talk about Aetna's proposed acquisition of Humana. My name is Mark Bertolini. I am chairman and CEO of Aetna.

There is no doubt that health care is under dramatic change at this time, and I think that change is good and long overdue. Health care costs are unaffordable and we are now beginning to focus on how we improve quality of care to reduce redundancy, waste, and improve the overall affordability of care.

To that end, the Aetna acquisition of Humana is about two companies coming together to offer a large number of consumers a broader and higher quality array of more affordable products. After the acquisition, Aetna will have a product portfolio balanced more evenly between commercial and government products, such as Medicare and Medicaid.

Today, the market competes on price and choice of doctor. This will not change. But to win in the market, we believe consumers should also be able to pick products that are focused on improving the health of the member.

The CDC has a term called Healthy Days. It is a simple survey that an individual takes to determine if they are having a healthy day. Both companies see this as an important metric. We both are committed to offering products and services that will help our members improve the number of healthy days they enjoy each year.

I would like to address the competition and choice issues directly. First, it is important to point out that of the 54 million beneficiaries in Medicare today, 37 million, or 68 percent, receive their care through Medicare fee-for-service, while the remaining 17 million, or one-third, receive their care through Medicare Advantage, M.A., the private Medicare option delivered through health plans.

Post acquisition, we believe that robust choice and competition will remain in the Medicare market. After the transaction, which is largely about Medicare and very little about commercial, only 8 percent of Medicare beneficiaries will receive their health benefits from Humana or Aetna, meaning that 92 percent of all beneficiaries will receive their health benefits from either Medicare fee-for-service or other M.A. plans.

There are 143 health care companies offering M.A. plans with new entrants coming into M.A. Twenty-eight new health plans have joined in the last 3 years, of which 15 are owned by hospital systems.

All health care is local, and today, M.A. is available in 3,100 of the 3,200 counties across the country. Beneficiaries have an average of 18 M.A. private health plan options from which to choose. And even in nonmetro or rural areas, there is an average of 10 plan options to choose from.

On the commercial side of the market, Humana represents less than 2 percent of the market and has no national employer market presence—zero. Today, Aetna represents under 12 percent of the commercial market. Nationally, there are 400 insurance companies operating in the commercial market, with the Blue Cross Blue Shield plan being the largest insurer in more than 30 States.

After the transactions, other companies will have 87 percent of the commercial enrollment. On public exchanges, Aetna and Humana overlap in only eight States. In those States, there are an average of 10 other competing insurers, so we believe there will be no material change to the competitiveness of the commercial health insurance market as a result of our transaction.

In regard to the price of our products, premium prices are driven by the underlying cost of care, such as hospitals, doctors, and prescription drug costs, which make up nearly 85 percent of premium prices. They are not derived in the abstract.

Given that this transaction is largely about M.A. prices, protection is even more assured because the government establishes M.A. rates based on the cost of health care in each county. Insurance companies offering M.A. plans must bid against the government benchmark as set forth in each county and are incentivized to be competitive. Hence, many companies offer zero dollar premium plans to consumers. In fact, M.A. premiums have decreased by 10 percent since 2010.

Certain medical societies have opposed our deal out of concern that it will affect the income of doctors. We believe that there will be no material effect on revenue for doctors as a result of the acquisition. However, we are committed to payment reform and believe the system must move from a fee-for-service model to a value-based model payment. We are working collaboratively with providers to align incentives around payment models that will reward the overall health of the individual that many providers support.

In closing, Aetna's acquisition of Humana is about creating positive change in the health care market. It is about being part of an effort to build a modern health care system built around the consumer. We believe that our acquisition will improve competition in the Medicare marketplace by providing affordable and higher quality products.

Thank you for the opportunity to testify today, and I look forward to your questions.

[The prepared statement of Mr. Bertolini follows:]

Mark T. Bertolini

Chairman and Chief Executive Officer

Aetna, Inc.

United States House of Representatives Committee on the Judiciary

Subcommittee on Regulatory Reform, Commercial and Antitrust Law

**“Healthy Competition? An Examination of the Proposed Health Insurance Mergers and the
Consequent Impact on Competition”**

September 29, 2015

I. Introduction

Chairman Marino, Ranking Member Johnson, and members of the Subcommittee, thank you for having me here today to discuss Aetna's proposed acquisition of Humana. My name is Mark Bertolini, and I am the Chairman and CEO of Aetna. Founded in 1853 in Hartford, CT, Aetna is a diversified health care benefit company that provides individuals, employers, health care professionals, and others with innovative benefits, products, and services. The Aetna acquisition of Humana is about bringing together two companies that are highly complementary, Aetna has traditionally been a large commercial health insurance company while Humana has been a large Medicare company known for its leadership and expertise in Medicare. After the acquisition, Aetna will have a product portfolio balanced more evenly between commercial and government products (such as Medicare and Medicaid).

While this deal is primarily about Medicare, coming together will enable us to offer more consumers a broader choice of products and access to higher quality and more affordable health plan options. With respect to Medicare, it is important to point out that of the 54 million beneficiaries in Medicare today, 37 million or 68 percent receive their care through fee-for-service Medicare, while the remaining 17 million or one-third receive their care through Medicare Advantage, the private Medicare option delivered through health plans.

Post-merger we believe that robust choice and competition will remain in the Medicare market:

- There are 143 health care companies offering Medicare Advantage plans, with new entrants coming into Medicare Advantage: 28 new health plans have joined over the last 3 years, – of which 15 are owned by providers.
- Today, in the over 3,200 counties across the country, Medicare Advantage is available in 3,100 of those counties.
- Beneficiaries have an average of 18 Medicare Advantage private plan options to choose from; even in non-metro (more rural areas) there is an average of 10 plan options to choose.
- After the transaction, only 8 percent of Medicare beneficiaries will receive their health benefits from Humana or Aetna, meaning that 92 percent of all beneficiaries will receive their health benefits either from either fee-for-service Medicare or other Medicare Advantage plans.

On the commercial side of the market, Humana represents less than 2 percent of the market and we are under 12 percent nationwide. Nationally, there are over 400 insurance companies operating in the commercial market with a Blue Cross Blue Shield plan being the largest insurer in more than 30 States. After the transaction other companies will have 87 percent of the commercial enrollment. On the public exchanges, in the 24 states where both Aetna and Humana operate, there is overlap in eight states. In those eight states, there are on

average 10 other competing insurers, so we believe there will be no material change to the competitiveness of the commercial health insurance market as a result of our transaction.

II. Dynamic and Changing Industry

The healthcare industry is rapidly transforming amid a highly competitive environment where a number of new companies have entered the market, providing consumers with more choice than ever before. Many of these new market entrants are delving into the health sector for the first time. For example, CVS Health and IBM recently announced plans to join forces to improve health care management services to patients with chronic diseases, with the help of advanced technology. Meanwhile, Apple has launched new apps that provide stronger links and information between patients and their doctors, and Google is making large investments in consumer health and telehealth. In the insurance space, start-up Oscar, with recently announced additional investment from Google, has built a successful new model with a consumer-centric approach focused on providing insurance through the exchanges in New York and New Jersey with plans to expand to other states. Earlier this month, the auto unions announced they were starting to contract directly with providers for the care for their members.

Many of these new market entrants reflect the industry's dramatic shift towards consumerism. A recent survey found that 60 percent of consumers prefer to take a lead role in decisions about their health care, while 80 percent believe a consumer oriented approach in health care is good for Americans. Consumers want and expect health care to be as easy to use as Uber or Amazon — there is no reason that health care should not be moving in the same direction as other industries.

Providers, as well, are rethinking their place in the health sector and expanding their traditional roles. Many providers are increasingly taking on insurance risk — through Accountable Care Organizations (ACOs), partnerships with insurers, and even starting their own insurance plans for sale on the exchanges and through Medicare Advantage. For example, this year, three health systems and providers sold their own health plans on the exchanges, and 63 other providers sold co-branded plans with an insurer. These patterns are also playing out in Medicare and Medicaid, for example, the number of Medicare beneficiaries selecting provider-owned Medicare Advantage plans rose 8.2 percent in 2013, while the number of Medicaid beneficiaries enrolled in provider-owned plans rose 15.3 percent. Over the past four years, there have been 28 new companies offering 104 new plan options in 24 states that represent 13.6 million Medicare beneficiaries. This year, there are 190 current Medicare Advantage contracts with provider owned/affiliated plans--just under 47 percent of these are hospital based health systems and with the rest sponsored by Long Term Care providers or physician groups.

Consumer Engagement

As a result of these industry-wide changes, a new economic model is emerging for health insurers. Competing on price alone is no longer enough; instead consumer engagement will be

key, especially as more individuals move from employer-based insurance to the individual market, where the consumer will determine where and how to access the health care system. We believe that to be successful, insurers will need to compete on price, but will win on how effectively they engage consumers to help keep them healthy and make it easier to navigate the health care system.

In our view, a consumer-centric model includes health insurance products that are simple and easy to understand. We want to create a shopping experience where people can easily compare plan prices and benefits, and understand upfront how much they would pay in the form of co-pays and deductibles when visiting a primary care doctor, specialist, or pharmacy. After enrolling we would stay engaged with customers, through apps and other technology in a similar way that people engage with their bank or Amazon after getting an Amazon Prime Account. We would use this technology to make it easier to deal with some of the more frustrating aspects of health insurance as well, such as provider billing, premium payment, and annual enrollment. And lastly, we would aim to help customers stay healthy by offering discounts on products such as exercise monitors or discounts for participating in metabolic testing that helps individuals better understand their health status and identifies concrete steps that can be taken so they can get healthier. Our goal is to simplify the consumer experience and when it comes time to re-enroll customers decide to choose Aetna because they experienced best-in-class service.

III. Fundamental Shift in Health Care Delivery

The model for providing health insurance is going through a fundamental shift in the U.S. Our health care system was largely designed in the 1960s and has many shortcomings, for example, public and private insurers typically pay for care based on volume (i.e., the number of services provided) rather than (be rewarded for getting a person back to the fullest health possible. Care has generally been delivered in “silos” rather than in a coordinated manner; and there is a great deal of inefficiency and waste. According to the Institute of Medicine (IOM), 30 percent of health spending — approximately \$750 billion in 2009 — was wasted on unnecessary services, excessive administrative costs, fraud, and other things that provide little value or improve patients’ health. Additionally, the sickest 10 percent of Medicare beneficiaries account for nearly 60 percent of total spending in traditional, fee-for-service Medicare. This population is more likely to suffer from chronic conditions, such as kidney disease, heart failure and Chronic Obstructive Pulmonary Disease (COPD), which are not only expensive to treat, but significantly diminish overall number of health day. More importantly, these Medicare beneficiaries too often do not get the type of seamless care they need and deserve to properly manage their conditions as they try to navigate a complex and confusing health care delivery system. Instead, these beneficiaries are in and out of numerous health care facilities, seeing sometimes dozens of providers and taking dozens of medications. Any yet, all of these services do not necessarily translate into higher quality of care.

As we work to address these deficiencies, the old “transaction” **volume** based model where insurers simply negotiated rates and paid health insurance claims is giving way to a new **value**

based model. This new value based model centers around integrated partnerships between payers and providers with incentives designed to keep people healthy. Both Aetna and Humana are committed to building a first class health services business designed to deliver value-based care that keeps our customers healthy. This will be no easy task, but we believe that together, we can take these critical steps forward.

IV. Health Insurance is a Competitive Marketplace with a High Level of Choice at the Local Level

The proposed transaction brings together Aetna and Humana's complementary capabilities in the highly competitive Medicare and commercial product segments while diversifying Aetna's portfolio. Aetna's experience will make Humana's commercial business more effective and competitive. Similarly, Humana's capabilities will make Aetna's Medicare business more effective and competitive by allowing Aetna to offer Humana's award-winning care and service model to the rapidly growing Medicare population.

We believe that the combination of Aetna and Humana will enhance competition at the local level by giving consumers a strong alternative to Blue Cross Blue Shield plans and other competitors. In this way, this combination is actually strongly pro-competitive. Even after the acquisition, Aetna will continue to face significant competition from a large number of health plans and other new market entrants such as ACOs.

Competition is vigorous in the Medicare program. Health care is local, and what matters most to consumers are the plan options and providers available to them in their areas. Nowhere is this more evident than Medicare, where Medicare Advantage plans compete against traditional fee-for-service Medicare and each other in over 3,000 counties across the country. Currently, 17 of the country's 54 million Medicare beneficiaries nationwide receive their benefits from Medicare Advantage plans. While Medicare Advantage enrollment has grown in recent years, 37 million — or two-thirds — of beneficiaries nationwide still choose to receive their benefits from fee-for-service Medicare. The choice between fee-for-service Medicare or Medicare Advantage is highly individual, and depends on a variety of unique circumstances and factors: for example, income, health status, the existence of retiree coverage for drugs and medical services, specific provider preferences, and travel frequency/ "snowbird" status. All of these factors are taken into account as beneficiaries determine what option best meets their health, financial, and other needs.

For the 37 million beneficiaries who remain in fee-for-service Medicare, they still must decide among Part D plan options and Medicare supplemental coverage, but what is clear given recent trends, more beneficiaries are choosing Medicare Advantage; since December 2010 Medicare Advantage enrollment has increased by 49 percent going from 11.8 million to 17.6 million today, and according to the Centers for Medicare & Medicaid Services (CMS) premiums have *decreased* by 6 percent.

The beneficiaries that elect to enroll in Medicare Advantage have numerous choices. Across the nation, 143 insurers offer Medicare Advantage plans including United, Kaiser,

Anthem, WellCare, Health Net, InnovaCare, Cigna, HCSC, local Blue Cross Blue Shield plans, provider-based plans, and others. This year, 94 percent of Medicare beneficiaries chose from at least five Medicare Advantage plan options. More specifically, 76 percent of Medicare beneficiaries have a choice of more than 10 Medicare Advantage plans, and nearly 58 percent have a choice of more than 18 plans on average in 2015. In the counties with the most robust Medicare Advantage enrollment in 2015 beneficiary choice ranges from 21-38 plans. In fact, 10.7 million or one-fifth of Medicare beneficiaries who live in one of the 30 U.S. counties with the highest Medicare Advantage enrollment have an average of 29 plan options. Good examples of this competitive environment are Harris County, TX where 470,000 beneficiaries have 37 plan options or Los Angeles, CA where 1.35 million Medicare beneficiaries have 34 plans to choose from. In rural America where there may be fewer Medicare Advantage plan options, a large proportion of Medicare beneficiaries remain in fee-for-service.

Beneficiaries choosing between Medicare Advantage plans have numerous tools at their disposal, including the “star ratings” calculated by CMS. CMS calculates star ratings from 1 to 5 (with 5 being the best) based on quality and performance for Medicare Advantage and Part D plans. Each plan’s star rating is available on the CMS website so beneficiaries, their families, and their caregivers can use this information to compare plans when they make their enrollment decision. According to CMS, about 60 percent of Medicare Advantage enrollees are currently enrolled in plans with four or more stars for 2015, an increase of approximately 31 percent compared to 2012.

Humana currently has 3.14 million Medicare Advantage members, compared to Aetna’s much smaller membership of just over 1.2 million Medicare Advantage members. Within Medicare, the two companies have different focuses, Humana’s Medicare offerings are primarily for individual consumers, while 44 percent of Aetna’s Medicare members are enrolled in retiree group coverage. However, both companies have high-quality star ratings.

While the transaction will enhance Aetna’s Medicare Advantage presence, the combined company will have 4.4 million Medicare members representing only 8 percent of the 54 million beneficiaries enrolled in Medicare. Moreover, this will occur at a time when Medicare is adding 10,000 new beneficiaries to the program each day and is expected to have 70 million enrollees by 2023.

Medicare is tightly regulated to protect consumers. In Medicare Advantage, companies bid against government-determined county-level benchmarks and operate within regulated profit limits. Medicare Advantage plans have strong incentives to bid below fee-for-service benchmarks, since plans that do so receive a percentage of the difference as a rebate, which they must use to provide extra benefits (like dental or vision coverage and cost-sharing reductions). Plans that bid above the benchmark do not receive rebates. To enroll in a plan that bids above the benchmark, beneficiaries must pay a premium equal to the difference between the Medicare Advantage plan bid and the FFS benchmark amount. Today, 79 percent of Medicare beneficiaries have access to a zero-premium Medicare Advantage plan; 48 percent of Medicare Advantage enrollees are enrolled in a zero-premium plan--more evidence of the

strong cost containment pressures and highly competitive environment. The same pressures will apply to the combination of Aetna and Humana.

In addition to regulating premiums, CMS scrutinizes Medicare Advantage plan bids to ensure that plans appropriately cover necessary services, meet stringent network requirements, and comply with a minimum medical loss ratio (MLR). The MLR measures medical costs as a percentage of premium revenues and limits what health plans can spend on administrative costs and profits by requiring them to spend the vast majority of premium dollars on providing care. This provides an after-the-fact backstop that directly limits the level of insurer profits.

Each year, beneficiaries have the opportunity to reevaluate their plans and “vote with their feet” by changing plans, or moving back to traditional fee-for-service Medicare during the annual open enrollment period. This framework keeps downward pressure on prices and upward pressure on quality.

Competition Will Also Remain Strong in Other Products

Beyond Medicare, there is very little overlap among Aetna and Humana’s other product lines. In the commercial market, Humana has less than 3 million members nationally (two percent of the national market) and has not sought to grow this business. Nationally, there are over 400 insurance companies in the commercial market. The most recent Government Accounting Office report on state-level concentration in commercial health insurance indicates that a Blue Cross Blue Shield insurer was the largest insurer from 2010-2013 in 44 states in the individual market, 38 states in the small group market, and 40 states in the large group market. Meanwhile, Aetna was the largest insurer in only one area (DC large group) and Humana was not the largest insurer in any area.

We anticipate the transaction will enhance competition in the public exchanges as well, where options are increasing for eligible enrollees. On July 27, 2015, the Department of Health & Human Services (HHS) announced that 86 percent of individuals eligible to enroll in the exchanges, had access to at least three issuers in 2015, up from 70 percent in 2014. Nearly 60 percent of counties experienced a net gain of at least one issuer, while only 8 percent of counties experienced a net loss of issuers.

In Medicaid managed care, Humana is a small player and not a close competitor of Aetna with a small number of Medicaid enrollees in four states (IL, VA, KY, and FL).

V. Benefits of the Acquisition for Consumers and Providers

Accelerating the Transition From a Volume to Value Based System. We see the acquisition of Humana as a way to accelerate the transition from a volume-based health care system (which reimburses providers based on the number of services performed) to a value-based health care system that improves the overall health of our members. The old insurance model of simply negotiating rates and paying claims does not meet the changing needs of our industry

and U.S. consumers. To survive, let alone thrive, stakeholders will need to collaborate with one another, including a renewed focus on quality.

Both companies know combining technology, with trusted provider partnerships, along with targeted disease and care management programs for high risk populations works. The below examples illustrate how Aetna and Humana have already had successful provider partnerships that resulted in improved health outcomes for consumers. Coming together will provide greater ability to accelerate the implementation of value-based payment models built around keeping members as healthy and productive as possible.

Improved Access to Value Based Care Models. Together with other like-minded private organizations, Aetna has made a pledge to have 75 percent of medical spend in value-based payment arrangements by 2020 — surpassing the goal set by CMS. Similarly, 54 percent of Humana beneficiaries are in accountable care relationships today (a total of 1.5 million Medicare Advantage members cared for by 33,000 primary care physicians in 43 states), and the company is on course to have more than 75 percent of beneficiaries in accountable care relationships by 2017.

Improve Quality. Humana's accountable care relationships are improving the quality of patient care delivered to its members. Humana Medicare Advantage members in accountable care relationships have a 4 percent lower hospital readmission rate than traditional, fee-for-service Medicare and 7 percent fewer emergency room visits. In addition, Humana's accountable care providers had an average Healthcare Effectiveness Data and Information Set (HEDIS) Star score of 4.25 compared to an average score of 3.65 for traditional fee-for-service providers.

Lower Costs. Both Aetna and Humana have already demonstrated success in lowering costs as well as improving quality through alternative payment models. For example, in 2013, Humana experienced a 19 percent overall cost improvement for Medicare Advantage members who were treated in an accountable care setting compared with members who were treated by other providers.

Similarly, Aetna's collaborations with the Memorial Herman Accountable Care Organization in Houston, Texas and Banner Health Network in Mesa, Arizona have led to positive results including consistent membership growth — showing that this type of care model and health plan is resonating — and cost and quality improvements. For example, Memorial Hermann has consistently improved efficiencies, and thereby lowered costs, in the self-insured population from 2013 to 2014 by:

- Increasing the generic prescribing rate by 21.3 percent;
- Reducing avoidable emergency room visits by 13.5 percent;
- Reducing the 30-day admission rate by 1.3 percent;

- Reducing impactable medical days by 55.8 percent; and
- Reducing impactable surgical days by 49.3 percent.

In addition, all six quality metrics that were measured during the same period of time exceeded their targets. These goals included improved screening rates for cancer and increased testing for patients with diabetes.

Likewise, Banner Health Network has experienced positive results through its collaboration. During the second year of the collaboration, Banner saw the following results in the Aetna Whole Health fully-insured commercial membership:

- 5 percent medical cost savings;
- 9 percent reduction in radiology services; and a
- 9 percent decrease in avoidable admissions.

Banner's leadership attributes much of its success to the mutual trust it built with Aetna.

In sum, these strengths of these two largely complementary companies will create a single entity better positioned to provide higher-value, lower-cost service to more consumers, well advance of HHS' goal to establish 50 percent of Medicare payments through value based payment arrangements via accountable care and alternative payment model arrangements.

Measuring Healthy Days

Another benefit of the merger will be that the combined company will gain Humana's - consumer-centered approach to measuring healthy days. Humana has developed a way to determine if we are achieving our mission to build a healthier world. The combined Aetna-Humana will measure its members' number of Healthy Days using a consumer-focused health measure originally created by the Centers for Disease Control. "Healthy Days" asks people about general self-rated health, and includes a total of four questions. Two of these questions focus on physical and mental health over the previous 30 days, and are used to derive an index of unhealthy days. Those questions are:

1. Now, thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?
2. Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

This questionnaire has been shown to provide a holistic view of a person's health, and to capture perceptions of health regardless of age, gender, race, or health condition.

VI. Next Steps

The July announcement of the Aetna acquisition of Humana is the first step in process that will be subject to both Federal and State review. Over the next several months, we will work with the appropriate Federal and State regulators to answer their questions as they review the transaction.

While it is too early to talk about organizational changes, you can count on our commitment to develop the most talented organization in the industry and to treat people with respect and dignity as we develop our integration plans. We have a long tradition in Hartford and expect that to continue. We will make Humana's location in Louisville the headquarters for our combined Medicare, Medicaid, and Tricare businesses. Founded in Louisville more than 50 years ago, Humana has a long history of contributing to the Louisville community, and the combined company will maintain a significant corporate presence in Louisville.

As part of our ongoing commitment to our employees, Aetna recently announced that we would increase our U.S. minimum base wage to \$16 per hour, effective April of this year. That increase is an average of 11 percent, and for some employees is as much as 33 percent. This will positively impact approximately 5,700 employees. As a result of this policy, we expect approximately 10,000 of Humana's employees to get a raise to \$16 per hour once we integrate the compensation structure of the two companies. In addition, starting in 2016 we will also offer to cover more of the health care costs for approximately 7,000 U.S. employees based on their total household income, where certain employees could potentially save up to \$4,000. In addition to the positive impacts this will have on our employees' household budgets, our hope is these initiatives will help reduce employee turnover in important consumer and provider facing jobs and better enable us to achieve our consumer-centric vision by having an energized workforce excited to come to work each day.

VII. Conclusion

The Aetna and Humana transaction brings together two highly complementary businesses in a sector that will continue to be marked by significant and dynamic competition. Combining these companies will enable us to offer consumers a broader choice of products, access to higher quality and more affordable care, and a better overall experience in more geographic locations across the country. Additionally, the combination of these two companies with top-rated Medicare plans, will allow us to accelerate the transformation from a model based on volume to one that is based on value and increases the number of healthy days a person enjoys each year.

Thank you for the opportunity to testify today, and I look forward to addressing any questions you may have.

Attachment 1 – Background Information About Aetna and Humana

Beginning as a Life Insurance Company in Hartford, Connecticut in 1853, Aetna now serves 46 million individuals with information and resources to help them make better informed decisions about their health care. Our health insurance plans and services include: medical, pharmacy and dental plans; life and disability plans; behavioral health programs; and medical management. These plans and services are provided by our 46,000 employees across the globe.

Locally, nationally and internationally, Aetna continues to innovate and grow our products and services. While our commercial business provides health benefits for 19.2 million of our 22.7 million medical members, we are continuing to expand our innovative consumer-directed plan options. To meet the needs of a changing marketplace, we offer a growing number of self-insured options, particularly in the middle market that serves employers with 100-3,000 lives. We also offer plans for individuals and small businesses in both public and private exchanges.

Aetna has also continued to strengthen its Government business, which currently includes membership in Medicare Advantage individual and group plans, Medicare Part D, Medigap, and Medicaid.

Humana is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. Humana has a long history of being a leader in providing innovative and high quality health plan choices to Medicare beneficiaries. The company's strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for millions of people it serves across the country. Humana insures over 9.7 million Americans, which includes providing Medicare benefits to over 3.1 million beneficiaries through the Medicare Advantage program and stand-alone Medicare Part D coverage to nearly 4.4 million members.

Mr. MARINO. A good standard to set, Mr. Bertolini. Right in on time.

Mr. Swedish?

**TESTIMONY OF JOSEPH SWEDISH, PRESIDENT AND CEO,
ANTHEM, INC.**

Mr. SWEDISH. Thank you, Chairman Marino, Ranking Member Johnson, and Members of the Subcommittee. I am Joseph Swedish, president and chief executive officer of Anthem, and it is my honor to appear before you today. The work of this Committee and the dialogue we engage in will help shape the future of health care in America. I appreciate the opportunity to contribute Anthem's perspectives and experience.

Several Committee Members represent communities served by Anthem's local health plans, and the Committee as a whole has been an influential advocate for positive change in health care. So I would like to begin by thanking you for your dedication, leadership, and partnership, and by reinforcing Anthem's commitment to continue our proud 75-year history of providing high-quality, affordable health benefits to the many local communities and diverse populations we serve.

My written testimony details the complementary nature of Anthem's and Cigna's businesses, the market dynamics impacting this transaction, and our commitment to working cooperatively throughout the review process.

But I would like to focus my remarks today on the most important beneficiaries of these proposed transactions—consumers. Health care is undergoing an unprecedented transformation. And while affordability, access, and quality are goals unanimously shared by our health care system, they are not universally enjoyed by consumers.

Together, Anthem and Cigna have the resources and capabilities to offer a broader portfolio of products and services to keep health benefits more affordable and promote accountable, higher quality health care for consumers. Simply put, the combination of Anthem and Cigna will allow us to provide better health insurance to more people.

We will keep health care affordable by more efficiently and effectively addressing the number one cause of rising costs in health care, the cost of care itself. Our combined analytic capabilities will empower better informed decisionmaking between patients and physicians and help safeguard affordable access to remarkable new clinical discoveries, treatments, and technologies.

Our combined health and wellness expertise will help fill gaps in recommended care and more proactively engage consumers in managing their own health conditions. We will expand access to a broader network of hospitals, physicians, and health care professionals so consumers receive the highest quality care available when and where they need it, and, finally, improve quality by expanding our innovative, value-based accountable care models that today represent more than \$50 billion in reimbursement tied to better value, quality, and outcomes for members.

Much of the attention around this acquisition focuses on competition. This is, certainly, an essential part of the dialogue. As a base-

line, it is important to recognize that health care is fundamentally local, locally based, locally delivered, and locally consumed.

Across the many diverse localities and business segments in which Anthem and Cigna operate, there is robust and growing competition. Given the very limited and in most areas no market overlap between Anthem and Cigna, competition will no doubt continue to flourish after the transaction is completed.

There are many calculations, analyses, and opinions being expressed about what this transaction will mean for competition, but the true question to be asked is, what will this mean for the consumer? The simple answer is Anthem and Cigna together mean better health insurance for more people.

Throughout my 40-year career in health care, I have worked diligently to instill a culture of innovation and collaboration across the many organizations I have led, and the combined company will be no exception.

Separately, Anthem and Cigna have made meaningful progress in improving affordability, access, and quality for consumers. Together, we can and will do much more.

We embrace the responsibility of this transaction and look forward to working with you and the entire health care system to expand access to affordable, high-quality health benefits.

Thank you for the opportunity to testify today, and I look forward to your comments and questions.

[The prepared statement of Mr. Swedish follows:]

Prepared Statement of

Joseph Swedish, President & CEO, Anthem, Inc.

Before the

**United States House of Representatives Judiciary Committee
Subcommittee on Regulatory Reform, Commercial and Antitrust Law**

On

September 29, 2015

Thank you, Chairman Marino, Ranking Member Farenthold, and members of the Subcommittee, for the opportunity to testify today. I am Joseph Swedish, President and CEO of Anthem, Inc., and it is my honor to appear before you today to provide an overview of the highly complementary nature of the proposed Anthem-Cigna combination and the value that would result for individual consumers, employers, providers and our health care system. The goal of this transaction is to provide a better product to these stakeholders in our ever-changing, increasingly competitive health care market – a product that promotes affordability, increases accessibility, and enhances quality by focusing on innovation and collaboration.

Since joining Anthem in March of 2013, I have witnessed the continued transformation of our health care system. Having spent more than 40 years of my professional life in health care leadership – the majority of those years serving as a hospital administrator and CEO for several major hospital systems, including Trinity Health, a faith-based health system – I am excited and hopeful about the future of health care.

Health care in our country is rapidly evolving, driven by the needs of consumers, who demand change from all sectors – providers and payers. Neither payers nor providers alone can bring about the change necessary to close the gap between consumer expectations and the outcomes that the health care system has historically delivered. Nor can this change be achieved by Anthem or Cigna alone. No longer is it enough for health insurers to serve as financial stewards in the health care delivery transaction; we must now assist consumers as they interact with the health care system, not just in choosing the health care options that best meet their needs, but also in helping them decide how and where to access care. Likewise, we must go beyond paying claims, instead partnering with providers by offering human and financial resource support, actionable data analytics, and tools that further their efforts to focus on the health of their patients, while shifting from volume- to value-based payments. And above all, we must help all stakeholders – providers, consumers, employers and brokers – change from a system that has historically focused on sick care to one that promotes optimal health. Anthem has taken this need for change head on by focusing on three strategic areas, which are the pillars of our proposed acquisition of Cigna: 1) a better consumer experience; 2) cost containment to improve affordability; and, 3) strong collaboration with providers.

My testimony today will focus on the following areas:

- *Value of an Anthem-Cigna Combination*
- *Complementary Nature of the Proposed Deal*

- *Marketplace Dynamics*
- *Federal and State Oversight of the Transaction*

Value of an Anthem-Cigna Combination to Consumers

The combination of Anthem and Cigna will bring together the complementary platforms of both companies in a way that will uniquely benefit consumers. For instance, Anthem recently opened its new Innovation Studio in Atlanta, GA with the goal of accelerating the pace of R&D and creating the tools, solutions and capabilities that will improve the experience of our consumer and provider partners. Through this program, we were able to launch our first pilot last month, a two-minute Welcome SmartVideo to new and renewing individual plan members in California. Anthem also brings an extensive network of providers, leading care coordination programs in Medicare Advantage and Medicaid, 24/7 access to licensed providers via telehealth, and more than 75 years of experience in commercial insurance. Cigna – through its “Go Deep, Go Global, Go Individual” strategy – brings its own distinctive strengths, including: consumer-centric technology platforms, highly regarded wellness programs, substantial expertise in the international market, and leading specialty capabilities like dental, vision, behavioral, and life and disability coverage.

Consumer engagement and data transparency

As health care evolves, consumers are demanding more information from a variety of trusted resources in order to make more informed decisions. When making health care decisions, many consumers look to their health plans, as they are the only entity with visibility across the entire health care system. We know that consumers want more transparency when it comes to their expected costs and the quality of health care provided by their doctors and hospitals. More importantly, we have seen that making this information available to consumers and providers leads to better outcomes and cost savings to the health care system. Anthem is responsive to consumer demands for transparency, which is why the company launched Anthem Care Comparison nearly a decade ago to provide consumers with price, patient experience and quality ratings for common, non-emergency medical services ranging from tonsillectomies to knee replacements, with the aim of empowering consumers to seek out the highest quality medical care in the most cost-effective setting. Anthem Care Comparison now includes approximately 400 medical procedures and services.

Anthem is also partnering with third party transparency vendors like Castlight Health and Health Care Blue Book to make sure consumers have clearer line-of-sight into the price variations that exist, oftentimes within the same geography or network. To encourage greater cost and quality competition among providers, and to help consumers make better informed decisions about where to seek health care services, we implemented a reference-based pricing program in partnership with CalPERS, the California Public Employee Retiree System. In coordination with CalPERS, we took on the problem of significant price variation across California providers for knee and hip replacements by utilizing reference-based pricing. By educating and incentivizing consumers and providers through price transparency, CalPERS experienced a 20 percent increase in patients who chose more affordable, high quality providers for these procedures, and at the same time, saw 20 percent of providers lower their prices.

Cigna, through the belief that consumers should be supported with the right tools to help them make value-based health care decisions, offers members myCigna cost and quality transparency tools. The myCigna portal is widely recognized as an industry leader, providing personalized cost estimates for 1,100 medical and dental procedures and real time pricing for medications at 60,000 pharmacies nationwide. In the last 12 months there were approximately 24 million customer visits to myCigna, with an additional 4 million visits to the mobile app. A primary destination for consumers is to find a local, quality and cost efficient doctor or facility; roughly a third of consumers visiting myCigna utilize the technology to identify pricing for procedures such as a colonoscopy, MRI or mammogram. Cigna's focus on wellness and consumer-centric technologies will only serve to enhance health coverage offerings when combined with Anthem's.

Improving quality and affordability

Consumers also want better value – in the form of higher quality and lower costs – for their health care. To that end, Anthem and Cigna are investing in several initiatives that focus on improving the value of health care for consumers, evolving beyond the traditional insurer role as a payer of claims to a personal health care coordinator for consumers. For example:

- Anthem's Enhanced Personal Health Care program promotes the physician-patient relationship through a stronger focus on the quality of, and access to, services, which has led to a net savings of \$6.62 per member per month, \$36 million in shared savings paid out to providers, and fewer hospital admissions and shorter hospital stays.

- Cigna Collaborative Care (CCC) is a value-based initiative that uses incentives to engage health care professionals and help drive improved health, affordability and patient experience. CCC represents an industry-leading 19 percent of total commercial contracts, and includes large primary care physician groups, hospitals, small primary care practices and specialists, including OB-GYN practices, among others. 82 percent of doctors and hospitals with two or more years of experience with CCC have had success in achieving their total medical cost targets and 72 percent had success in achieving their quality targets.
- With spending on cancer medication expected to increase by 50 percent through 2024, 25 percent growth in new cancer therapies that average an annual cost of \$100,000 each, and one in three cancer patients receiving treatment that is not consistent with medical evidence or best practices, Anthem's Cancer Care Quality program – a joint collaboration with providers and oncologists that seeks to arm these experts with the information and tools they need to identify evidence-based care paths – has advanced better informed decision-making in cancer care and treatment. In its first year, 65 percent of members in the sample are already on a high-quality pathway.
- As part of Cigna's efforts in wellness programs, the City of Houston, Texas is the recipient of the Government Sector Well-Being Award for its dynamic and engaging wellness program, which includes completion of the annual health risk assessment with biometrics and participation in various activities including health education seminars, preventative care visits, and completion of coaching programs. The City has realized an estimated savings of \$42 million in health care costs over the last three years and lowered its average annual health care trend increase to 1.1 percent, down from 10 percent.
- Anthem's Imaging Cost and Quality program is proactively engaging consumers by educating them about lower cost, high quality alternative locations to receive care for certain procedures, like MRIs, which can save \$220 per test, on average.

The combined reach of Anthem and Cigna would go even further by providing these kinds of programs and expanding access to care and choice for consumers through a more extensive network of hospitals, physicians, service providers, and health care professionals, including a combined network of more than 1,600 Centers of Excellence proven to produce higher quality and lower costs in a number of surgical areas, such as cardiology, orthopedics, oncology, and obstetrics.

Together, Anthem and Cigna would also be able to leverage complementary expertise in serving Medicare beneficiaries with chronic conditions. For example:

- Anthem, through our CareMore Health subsidiary, has demonstrated that by investing in care during the earlier stages of a beneficiary's illness or condition, and through strong collaboration with primary care physicians and bricks and mortar care centers, not only is the progression of illness slowed, but, when compared to traditional Medicare fee-for-service, overall health costs are reduced. For instance, through CareMore's unique and member-focused approach, its members with chronic kidney disease (CKD) progress to dialysis in slightly over 24 years, as opposed to less than six years for beneficiaries with CKD in fee-for-service. Also, through its disease management programs, CareMore has reduced stroke risk for its members by 40 percent and amputation rates for diabetics by 60 percent.
- At the same time, Cigna's HealthSpring subsidiary – in complementary locations across the country – partners with physicians to transition to alternative payment models. Almost two-thirds of Cigna-HealthSpring's members in HMOs receive care through physicians who are incentivized to deliver better outcomes and higher patient satisfaction. For instance, Cigna-HealthSpring members receive: 19 percent more colonoscopies, which lower the risks associated with colorectal cancer; 11 percent more mammograms, which lower the risks associated with breast cancer; and, six percent more diabetic cholesterol screenings, which lower the risks associated with heart attacks and stroke.

Provider collaboration and value-based reimbursement

Among the challenges impeding the needed change to our health care system is an antiquated fee-for-service payment system that rewards volume over quality while restricting provider collaboration. This challenge is equally recognized, and is being prioritized, by health insurers, providers, the Administration, and Congress.

In January 2015, the U.S. Department of Health and Human Services announced (during an event attended by Anthem's chief medical officer, Dr. Samuel Nussbaum) a historic timeline for shifting 50 percent of Medicare payments from fee-for-service to quality- and value-based through the adoption of alternative payment models by 2018. In addition, Congress, through passage of the Medicare and CHIP Reauthorization Act of 2015 earlier this year, reformed Medicare physician payment by setting a course

for consolidating quality reporting requirements and creating a new reimbursement structure for physicians based on medical outcomes, instead of the volume of services provided in the previous SGR methodology.

Anthem and Cigna are also committed to aligning incentives to encourage smarter, collaborative decision-making that fosters healthier outcomes and a better patient experience. More than \$50 billion (53 percent) of Anthem's total health care reimbursement is tied to value-based contracts, with 150 accountable care organizations (ACOs), 787 hospitals, and 106,000 network physicians. In fact, through our new Enhanced Personal Health Care arrangement with participating providers – where the emphasis is on value-based payments rewarding high quality and efficiency, the exchange of clinical information, and a mutually-shared commitment to patient-centered care – Anthem is able to serve 4 million of our members. This focus has allowed us to get more care provided under the value-based umbrella – a number that will only grow as a result of the proposed deal, having a more immediate impact on our ability to bring down the total cost of care. Anthem also has a first-in-the-nation partnership with seven of the top 30 competing hospital systems in Los Angeles and Orange County, that enabled us to launch Vivity, an integrated health system that moves away from traditional fee-for-service and towards a structure that financially rewards activities that keep patients healthy, both simplifying access and making costs more predictable.

Meanwhile, eighty percent of Cigna-HealthSpring's Medicare Advantage membership is tied to value-based reimbursement. In addition, more than 35 percent of Cigna's total commercial health care reimbursement is being tied to value-based contracts, primarily through its aforementioned Cigna Collaborative Care (CCC) initiative, which includes arrangements with 134 large physician group practices, more than 30 specialty groups, and over 80 additional arrangements covering more than 240 individual hospitals. CCC works to bridge the gaps in information and care by creating a model that rewards for quality outcomes and gives health care professionals the information – and the support – they need to achieve those outcomes. And the results speak for themselves:

- *Improved health* – with 3 percent better-than-market average quality performance; 19–25 percent better compliance rate with diabetes measures; and, 21 percent more gaps in care closed.
- *Lower cost* – with 3 percent better-than-market average total medical cost; 52 percent conversion rate to lower cost medications; and, 4–5 percent lower total medical cost trend versus peers.

- *Higher satisfaction* – 95 percent of participating doctors would recommend Cigna to colleagues; and, 50 percent fewer emergency room visits compared to market benchmarks, contributing to a higher quality of life.

By integrating the complementary expertise of the two companies, the combined organization would operate more efficiently, reduce overall operational costs, and enhance our ability to manage the cost drivers that negatively impact affordability for consumers.

Complementary Nature of the Proposed Deal

As the health care system continues to change, insurers must change along with it. From delivery to payment to how and where consumers interact with their care, the health care landscape has undergone a dramatic shift – one that will only continue as we move further down the road towards a more fully integrated, value-based health care system.

The health insurance industry has adapted along with this change and will continue to reshape the role it plays in consumers' lives. First, consumers have become savvier and much more engaged in their health care decision-making. This engagement has boosted the prevailing spirit of competition that thrives across the insurance industry today, as companies innovate to bring customers the products they want. This innovation, in turn, has encouraged a greater spirit of collaboration with health care providers, moving insurers beyond the traditional role as payer of claims, to one of partner in improving the delivery and quality of care. In particular, we are in the midst of a comprehensive redesign of how we pay for health care, by focusing on reimbursement models that reward value and outcomes, rather than volume.

However, facilitating consumer engagement and the shift to value-based payment models requires in-depth data. Consumers need transparent, easy-to-understand information on quality and costs. Providers need real-time data on their patients, as well as on evidence-based interventions, that will enable them to address gaps in care and better manage chronic conditions. Anthem's proposed merger with Cigna will result in the aggregation of useful information that can then be applied to bringing a better, more targeted, product to consumers, and ultimately, improving the care that providers are able to deliver patients.

Additionally, as already touched upon, both companies bring distinct capabilities and expertise to the transaction. In such a rapidly-changing environment, where the pace of development is outmatched only by consumers' demand for tapping into these advances, companies face the critical decision of either

dedicating resources to building out new capabilities or identifying organizations that have already distinguished themselves in these areas and combining their shared expertise in order to bring consumers the best possible product in a responsive and timely way. As it relates to this transaction, the combination of these two companies would enable the merged organization to expand the reach of the things each does well. Whether that's Anthem's focus on value-based provider collaborations through its Enhanced Personal Health Care program or Cigna's dedication to improving health, affordability, and the patient experience through its Cigna Collaborative Care initiative, this deal enhances our ability to bring consumers a wider array of products, while improving our stewardship of their health care needs. Put simply, an Anthem-Cigna combination would allow us to bring the best of what both companies do to more people today.

And, it must be emphasized, in addition to being personal, health care is local – it is delivered and paid for locally, even when administrative functions are located elsewhere. To characterize Anthem and Cigna as two of five “national insurers” is inaccurate and an oversimplification of the role we play in the varied communities we serve across the country.

Health insurance is flush with competition. The number of health insurers increased by 26 percent in 2015 with 70 new entrants offering coverage. Increased competition in insurance means more choices for consumers. Further, when considering the various segments that make up health insurance (individual, small group, international, large employer, Medicare Advantage, Medicaid, etc.), it is apparent that this transaction will result in minimal shared local markets, both geographically and by product segment.

As the BlueCross or BlueCross BlueShield licensee in 14 states, Anthem is intimately familiar with the rules governing how insurers can operate under this brand. While the rules require that companies meet certain thresholds to stay in compliance – at least two-thirds of all health care revenue across the country must be derived from Blue-branded business; 80 percent of the revenue in those states that that company operates under that brand – we are confident that we will continue to remain in compliance with those rules with more than sufficient flexibility to compete aggressively in the markets in which we will do business under the Cigna brand. The BlueCross BlueShield Association does not have approval rights over this transaction. However, if it is determined at any time that we are out of compliance with their rules, we are allowed a grace period during which we will be able to develop an action plan and granted additional time to come back into compliance.

At Anthem, we look at the provision of small group as insurance plans for small employers with 2-50 employees; we have a presence in this segment in 14 states. Cigna does not market to this group. Likewise for purchase of individual plans, where consumers obtain coverage directly for themselves, often through the exchange marketplace or a broker, Anthem, again, has a presence in 14 states. Cigna has a presence in 12 states. The combined company would only share a limited number of rating regions within just five states, where there is now, and will continue to be, robust competition. Underscoring this is the fact that consumers can now choose from an average of 40 health plans in states participating in the insurance exchange marketplace – an increase of 25 percent in 2015.¹ In local exchanges, consumers have an average of 23 different plan choices at the silver metal level. Further, new business models – CO-OPs like Community Health Options, licensed in Maine and New Hampshire, and venture capital-backed companies like Oscar Healthcare – are entering this segment and expanding their coverage, along with provider-sponsored health plans and plans that have traditionally served other segments. The Silicon Valley-backed startup, Oscar provides yet another model of entry. Oscar is a new entrant that leverages technology and promises to offer a new way to purchase and use insurance. It is emblematic of the changing face of the competitive landscape in the insurance industry. With significant investment from companies like Google, who recently announced \$32.5 million in new funding, Oscar has already signed up more than 40,000 people in New York and New Jersey, the first and only markets it has entered, with plans to expand to California and Texas in 2016.

Large employers also have numerous choices and the ability to leverage additional competitive alternatives. Across the country, at least 130 unique health benefits companies compete to serve employers that self-insure health benefits for their employees. This number does not include the several Pharmacy Benefit Managers and Behavioral Health Organizations that also serve large employers. For this segment, companies like Anthem and Cigna primarily provide administrative services rather than insurance, because employers take on the risk of providing health care coverage by self-insuring. Today, large employers seldom purchase one all-inclusive health benefit package for employees located in facilities in multiple states. Large employers frequently contract with health insurers, third party administrators, and providers on regional, state, and local levels, depending on the local market conditions, to offer additional options to their employees. In addition, employers often disaggregate or carve up health benefits into product segments (e.g., medical, dental, vision, pharmacy, life and disability,

¹ U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Plan Choice and Premiums in the 2015 Health Insurance Marketplace*, <http://aspe.hhs.gov/sites/default/files/pdf/77176/healthPremium2015.pdf> (Jan. 8, 2015).

etc.) and issue separate RFPs, generally by geographic region, to ensure the most efficient use of their dollars.

Large employers also benefit from being able to supplant traditional insurance providers in some areas of the country with well-established, integrated health care delivery systems (e.g., Mayo Clinic Health System, UPMC, Henry Ford, Geisinger Health System, Health Partners of Minnesota, etc.) and new entrants like Ascension Catholic Health, Tenet/Vanguard and North Shore-LIJ Health System. At the same time, there are several companies offering rental networks (e.g., MultiPlan and PreferredOne), risk management and administrative support (e.g., CoreSource, HealthPlan Holdings, Associated Third Party Administrators, etc.), and technology like telchhealth (e.g., Teladoc, Specialists on Call, MDLive, Doctor on Demand, etc.) as stand-alone products and services to large employers. This has led to robust competition for these various segments and services. Even Anthem, as an employer of 52,000 associates, utilizes partnerships with companies like HealthEquity and CONEXIS for Flexible Spending Accounts, Health Savings Accounts, and COBRA benefits.

Large employers – like Walgreens, Starwood, Sears, and Petco – are also utilizing new private health insurance exchange models to provide several health coverage options for their employees. In 2016, almost 30 percent of Anthem's quotes for new business with large employers have been quoted through a private exchange. During the same time period, nearly 25 percent of Cigna's relationships with large employers are projected to be sold through a private exchange, up from three percent of client relationships in 2014. According to a recent report by Accenture, private health insurance exchange enrollment doubled from 2014 to 2015, and private exchange enrollment is estimated to reach 40 million by 2018. Some large employers are even negotiating directly with local health care systems. For example, according to a recent article in *Modern Healthcare*, Boeing is contracting directly with Roper St. Francis Health Alliance in Charleston, SC, Providence-Swedish Health Alliance in Seattle, WA, and with Mercy in St. Louis, MO.

The combination of Anthem and Cigna, through complementary product and geographic focuses, will only enhance our ability to serve the needs of large employers. Cigna is providing leading health services to employers that choose to self-insure, employers in need of stop-loss coverage, and employers with globally mobile employees. At the same time, Anthem is providing large employers a robust network of doctors and hospitals, and new collaboration and care delivery models grounded in value-based care that improve quality of care and help employers control rising health care costs. In addition, Cigna's highly-regarded integrated behavioral, pharmacy, vision, dental, and other specialty products will expand options

and enhance health. One hundred percent of the savings that result from Anthem and Cigna care management programs are passed through to large employers that self-insure.

For employers and organizations with multi-national footprints, Cigna has partnerships in 30 countries to provide health coverage to their globally mobile employees through a vast network of over 1 million health care professionals, clinics, and facilities. This network includes 89,000 behavioral health care professionals and over 11,000 facilities and clinics, 74,000 pharmacies, nearly 70,000 vision health care providers in more than 24,800 locations, and over 150,000 dental professionals. Anthem does not operate in the international market.

For Medicare Advantage (the private plan alternative to Medicare fee-for-service), the total membership for the combined company would be minimal (a six percent share combined, according to a recent analysis by the Kaiser Family Foundation, which amounts to about one million covered lives for the combined organization). Anthem does business in 20 states, primarily in New York, Ohio, and California. Cigna, meanwhile, does business in 15 states and the District of Columbia, primarily in Florida, Tennessee, Pennsylvania, and Texas. The companies thus have a highly complementary geographic footprint. On average, all Medicare beneficiaries are able to choose from 18 Medicare Advantage plans in 2015.²

While Anthem has contracts in 19 states to serve Medicaid beneficiaries, Cigna's footprint is limited to just a number of counties in two states, resulting in both companies offering Medicaid Managed Care services in only six shared counties in Texas. It is important to remember that the states determine the rates that are paid to plans, how many plans may participate, where those plans can do business, and who those plans can serve. And, even within this structured model, the competition through RFPs is vigorous. Many states also divide the Medicaid population by geography or beneficiary group (i.e., mothers and children; single adults; dual eligibles – those qualifying for both Medicaid and Medicare; long-term care, etc.). Anthem has a large number of competitors including UnitedHealthcare, Centene, WellCare, Molina, AmeriHealth, and others. For example, just last month the state of Iowa completed a competitive bid process for the management of the state's Medicaid population. In the case of Iowa, 11 health plans submitted bids, with four being awarded state-wide contracts, which means Medicaid beneficiaries will have four health plans from which to choose.

² Gretchen Jacobson, et al., *Medicare Advantage 2015 Data Spotlight: Overview of Plan Changes*, The Henry J. Kaiser Family Foundation, <http://files.kff.org/attachment/data-spotlight-medicare-advantage-2015-data-spotlight-overview-of-plan-changes> (Dec. 2014).

Other Notable Marketplace Dynamics

As noted above, health plans are entering new business segments, and new entrants are participating in the market for the first time. Providers are also entering the health insurance marketplace in rapidly growing numbers. According to a PwC analysis from 2014, “some 50 percent of U.S. health systems have applied – or intend to apply – for an insurance license.”³ Just a few examples of health systems that have entered the insurance market include: Ochsner Health System, Sentara Healthcare, Tenet/Vanguard, and Ascension Catholic Health.

Given the high degree of health insurance regulation at both the federal and state level, plans are mandated to incorporate an expanding set of rules into their business models. In addition to the stronger-than-ever consumer protections now in place, health plans’ rates and operating margins are more regulated than ever before. For example, newly-established mandates limit how health insurance plans spend the premium dollars that they collect; specifically, in terms of the percentage of each premium dollar that can be spent on “administrative expenses” versus medical claims. As a result, plans are incentivized to find greater efficiencies within these categories. The shared competencies of these two organizations will enable the combined company to operate more efficiently (e.g. leveraging IT capabilities), thereby reducing operational costs, while enhancing quality of care and investments in technology and innovation.

Federal and State Oversight of the Transaction

While I am grateful for the opportunity to share our perspective on the benefits and inherent value of the combining of these two forward-thinking companies, I also recognize that we are only at the beginning of what we expect and hope will be a thorough, fact-based, and comprehensive examination of the merits of this transaction. Anthem’s proposed acquisition of Cigna is subject to vigorous federal and state regulatory review processes, throughout which you have my assurance that both companies are committed to working cooperatively with all relevant policymakers and regulatory entities.⁴ We hope to

³ Gary Ahlquist, et al., *Several hundred health networks will become payors*, PwC, <http://www.strategyand.pwc.com/global/home/what-we-think/reports-white-papers/article-display/health-networks-become-payors> (June 20, 2014).

⁴ As it relates to the *McCarran-Ferguson Act*, the law has been interpreted to not include mergers and acquisitions as “the business of insurance.” As such, this transaction is subject to full and complete regulatory review by the Department of Justice, similar to any other proposed merger or acquisition.

close this transaction in the next 12-16 months. We have met with the Department of Justice and with the National Association of Insurance Commissioners, and have been engaged in our state filings. And, we are committed to remaining transparent throughout the entirety of this process about our plans with all of our stakeholders and interested parties.

Conclusion

I want to thank the members of this Subcommittee again for holding this hearing and providing me the opportunity to speak on behalf of the proposed transaction, which, as I have detailed, would bring together two highly complementary organizations. We look forward to the regulatory review process and to working jointly with the entities responsible for the transaction's oversight and approval.

Health care markets are constantly changing – whether as the result of legislation or the imperative to meet the needs of consumers and providers. To serve consumers best, health care organizations must evolve and become more sophisticated. Over the past five years we have faced many new competitors locally and by product segment – ranging from hospital systems to new Medicare Advantage and commercial entrants to disaggregated services sold directly to employers. These delivery systems hold tremendous promise for consumers, and their local and market segment strength as competitors demonstrates why antitrust review from regulators and policymakers should generally examine the various segments that make up health insurance (e.g., individual, small group, Medicare Advantage, etc.) independently rather than assume that decisions are uniformly made on a national basis.

Finally, I believe it also worth repeating that, at its core, the proposed Anthem-Cigna combination represents a significant step forward on the path to a 21st century health care system that reflects our shared vision of greater value for consumers – increased access and choice, greater affordability, and the better health outcomes achieved through innovation and collaboration. I look forward to your questions.

Thank you.

Mr. MARINO. Thank you.
Mr. Nickels?

**TESTIMONY OF TOM NICKELS, EXECUTIVE VICE PRESIDENT,
AMERICAN HOSPITAL ASSOCIATION (AHA)**

Mr. NICKELS. Thank you, Chairman Marino, Ranking Member Johnson, and other Members of the Subcommittee. Thank you for inviting me here today. My name is Tom Nickels. I am executive vice president of the American Hospital Association. On behalf of our 5,000 hospitals and health system members and the patients we serve, I appreciate the opportunity to testify today.

Anthem's proposed acquisition of Cigna and Aetna's proposed acquisition of Humana would further concentrate an already heavily concentrated health insurance industry by eliminating two of the largest five insurers and result in negative consequences for both health care consumers and providers.

Many consumer groups and provider organizations have already expressed significant concerns about these massive acquisitions, and we believe both deals merit the highest level of scrutiny from both Congress and the Department of Justice. I would like to focus on some of our specific concerns with each deal and take issue with a number of claims some are making to try to defend the proposed acquisitions.

First, the insurers claim they are seeking to acquire companies that have complementary business lines and that there would be no overlaps leading to increased market consolidation. We are very skeptical of these claims.

In addition, given Anthem's affiliation with the Blue Cross Blue Shield system, we are concerned about the negative consequences for consumers and health care providers that could result from further entrenching the powers of the Blues' plans that currently dominate the insurance market in nearly every State.

Second, the insurers say that all health care is local. However, they cite national statistics on the number of competitors instead of the actual competition in local markets. According to our analyses, which are done in the same manner and with the same data that the DOJ will use in making competitive assessments, more than 800 markets for the Anthem deal and more than 1,000 markets for the Aetna deal lack sufficient local competitive alternatives.

In addition to the lack of competition in local markets, there are high barriers to entry in the commercial insurance market. For example, insurers point to Oscar as a new commercial health insurance company. However, it is one of only two for-profit companies that were not already insurers to enter State marketplaces so far. It also has penetrated only a single urban market and lost a reported \$27.5 million last year. The company's founder recently described entry into the insurance market as "daunting."

Meanwhile, the Aetna-Human deal would affect Medicare Advantage plans in more than 1,000 markets that serve more than 2.7 million seniors. These markets would become even more concentrated, and 97 percent are already highly concentrated. The potential for further concentration would threaten the fiscal protection the Medicare Advantage program provides for enrollees and

would likely result in higher out-of-pocket costs and fewer benefits and even narrower networks.

Just yesterday, the GAO released a report urging CMS to do a better job of ensuring that networks are adequate.

Third, we are very concerned that both of these deals could derail the momentum hospitals have led to improve the Nation's health care delivery system. Despite claims that commercial insurers are fostering innovation, they continue to benefit financially from both squeezing provider payments and riding the wave of hospital efforts that are resulting in more efficient and higher quality care.

There is no evidence that larger insurers are more likely to implement innovative payment and care management programs. In fact, concentrated delivery system reform efforts have tended to emerge from other sources, such as provider systems and non-national players.

Fourth, we are concerned that any potential benefits the insurance companies realize from these deals will not be passed on to consumers. Insurers do not have a good track record of passing any savings from an acquisition on to consumers, and there is no reason to believe these transactions would be different.

Fifth, if these deals are allowed to close, the negative impact on providers and consumers could be enduring. Consolidation that occurs now is unlikely to be undone if it later proves anticompetitive.

Lastly, it is unlikely that divestiture agreements can be reached to reduce the anticompetitive impacts. It is also unlikely that other competitors have the capacity to enter these markets as the scope and scale of the acquisitions are unprecedented.

In conclusion, some have compared the insurance deals to those in the telecommunications arena because of the size and potential to contort the market and harm consumers. DOJ was ready to challenge the telecommunication deals, and it also should be ready to challenge these insurance deals, if it finds that these transactions threaten the vitality of our health care system and the health and welfare of consumers across the Nation.

We look forward to working with the Subcommittee to make sure that consumers continue to have access to high-quality, affordable health care in their communities. Thank you very much.

[The prepared statement of Mr. Nickels follows:]



800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

**Testimony
of the
American Hospital Association
before the
Subcommittee on Regulatory Reform, Commercial and Antitrust Law
of the
Committee on the Judiciary
of the
U.S. House of Representatives**

**“Healthy Competition? An Examination of the Proposed Health Insurance Mergers and
the Consequent Impact on Competition”**

September 29, 2015

I am Tom Nickels, executive vice president 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.

The AHA has expressed concern in numerous forums about the proposed acquisition of Cigna by Anthem and Humana by Aetna. These acquisitions would further concentrate an already heavily concentrated health insurance industry. In addition, any potential benefits the deals could yield pale in comparison to the enduring harm the deals could impose on health care consumers and providers. Many consumer and provider organizations have raised similar concerns, urging that these deals receive the closest possible scrutiny by federal and state antitrust authorities.

Among the claims that the insurers make to defend the acquisitions of their closest competitors are that the companies are complementary without significant overlaps and/or allow them to extend to lines of business they could not enter otherwise. These claims have – and should have – been met with significant skepticism. That also is true of their statements declaring that all health care is “local,” followed by a recitation of national statistics on the number of supposed



competitors to imply that there is more than sufficient competition in local markets. However, this is not the case. If all health care is local, then only the competitors in a particular local market count in assessing the anticompetitive impact of the deal. Our analyses, which are done in the same manner and with the same data that the Department of Justice (Department) would use in making competitive assessments, show that more than 800 markets for the Anthem deal and more than 1,000 markets for the Aetna deal lack sufficient “local” competitive alternatives.

The same attempt at obscuring applies to claims by Anthem that its Blue Cross Blue Shield (Blue) affiliation would not limit its ability to deploy the Cigna business as an effective competitive force or further entrench the dominance of Blues plans across the nation. “The Blues’ license agreements severely restrict the Blues’ ability to compete with each other,” and that has tremendous anticompetitive potential, perhaps even beyond those we have identified.¹

Both of these proposed deals could be an enduring blow to consumers as well as hospitals, doctors and others who work to improve the quality, efficiency and affordability of health care. As Professor Leemore Dafny highlighted in her recent testimony before the Senate, health insurance “consolidation that occurs now is unlikely to be undone if it later proves anticompetitive,” as most expect it will.²

Hospitals’ momentum to move the nation’s health care system forward could also sustain long-term irreversible damage as a result of these deals. 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. As Dafny noted, “[t]here is no evidence that larger insurers are more likely to implement innovative payment and care management programs ... [and] there is a countervailing force offsetting this heightened incentive to invest in ... reform: more dominant insurers in a given insurance market are less concerned with ceding market share.”³ In fact, “concerted delivery system reform efforts have tended to emerge from other sources, such as provider systems ... and non-national payers,” according to Dafny, not commercial health insurers.⁴

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’s Antitrust Division our serious concerns about the recently announced acquisitions.⁵ 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.”⁶

Concentration Matters. A recent study⁷ 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.”⁸

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 the substantial competition between them by creating artificial “submarkets” 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.

Entry is Daunting. The durability of the likely anticompetitive impact is enhanced because of the high barriers to entry in the commercial health insurance market. The Department has explicitly acknowledged this and, remarkably, little has changed over the three years since that authoritative pronouncement.⁹ The insurers point to some recent new entries to suggest that the barriers are lower now; however, this could not be further from the facts.

Specifically, the insurers point to Oscar, one of only two for-profit “companies that were not already insurers ... to enter state marketplaces so far.”¹⁰ To date, Oscar has penetrated only a single urban market (New York/New Jersey) and is attempting to enter two more in 2016.¹¹ In doing so, it lost a reported \$27.5 million last year, or about half of its 2014 revenue.¹² In addition, it does not discount the immense difficulty of building this business in a market “dominated by powerfully entrenched business;” the company’s founder described entry into the insurance market as “daunting.”¹³

This month, the *New York Times* chronicled the failure of numerous health insurers across the nation, citing a report that “eight carriers have dropped out of nine states” so far.¹⁴ The fact remains that “the most likely potential entrants in a [health insurance] market are incumbents in other product and/or geographic markets,” such as the companies seeking to consolidate now.¹⁵

As Dafny noted in her Senate testimony, claims of offsetting efficiencies cannot ameliorate the competitive harm from this deal. “Efficiencies must be merger-specific and verifiable ... and there is still the question of whether benefits will be passed through to consumers in light of that diminished competition.”¹⁶ 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.¹⁷

Legislated Controls Cannot Prevent Premium Hikes. 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. Among other things, the MLR is “gameable” by insurers.¹⁸ Our MLR factsheet is attached.

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 premiums 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*¹⁹ 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. Our rate review factsheet is attached.

Anthem’s Affiliation with the Blue System Raises Concerns. Anthem’s affiliation with the Blue Cross and Blue Shield system raises some particular competitive concerns. An August 2015 letter²⁰ 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 Varney²¹, 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.

Anthem has yet to provide a cogent explanation of how it could comply with Blues' rules *and* deploy Cigna as an effective competitor. Suggesting as Anthem did at the September 22 Senate hearing that it has two years after the deal closes to work out an arrangement surely cannot convince officials or others that the Blues' rules should not be a primary consideration in disallowing the acquisition.²² In addition, Anthem's market segmentation argument does not alleviate the competitive concerns that arise because of the control local Blues plans will have over Cigna lives as a result of this deal. Bolstering the dominance of local Blues plans in this manner will further harm consumers and providers in virtually every state and increase what are already formidable barriers to entry in the health insurance markets in these states.

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.²³ The report highlighted the problems the antitrust agencies face in trying to turn “smaller firms into large competitors capable of absorbing major divestitures” in an area this complex.

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.²⁴ 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.²⁵ 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.²⁶

Aetna’s Acquisition of Humana Could Further Concentrate Medicare Advantage (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 MA population is up 7.3 percent from this time last year, according to the latest data from the Centers for Medicare & Medicaid Services (CMS).²⁷ 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.²⁸ As recently as 2014, Aetna appeared to believe it was capable of growing its MA business substantially without this acquisition.²⁹

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 Fund³⁰, 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 Foundation³¹ 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 Avalere³² (on which the insurers seem to base most of their arguments about “new competition” in MA) 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. And, like any

new entrant, they can be susceptible to anticompetitive market strategies deployed by entrenched commercial insurers. Furthermore, some skepticism should be applied to any characterization of a Blue plan as a new entrant into a health insurance market; Dafny notes that the Blues have had a 10 percent share of the MA market since 2007.³³

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.”³⁴

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 “siloed” 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 of care 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 hospitals realign. 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. 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 Fitch Rating report confirms this; starting in 2011, the profitability “metrics” for the lowest-rated hospitals have declined.³⁵ 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 Joe R. Whitley, Jr., letter to the Honorable William Baer, August 13, 2015.

² Testimony of Professor Lecmore S. Dafny, Ph.D., Professor of Strategy, Kellogg School of Management Northwestern University, before the Senate Subcommittee on Antitrust, Competition Policy, and Consumer Rights on "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?" (Dafny Testimony) September 22, 2015 at 3.

³ Dafny Testimony at 16.

⁴ Dafny Testimony at 16.

⁵ AHA letter to the Honorable William Baer, August 5, 2015, and AHA letter to Baer and Secretary Sylvia Burwell, September 1, 2015, www.aha.org/letters

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- ¹⁸ Dafny Testimony at 3.
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- ²¹ 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>.
- ²² Remarks by Anthem's president and CEO during Senate hearing on September 22, 2015.
- ²³ 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.d?l?s=dd&id=13291361&cnpid=cm:DA091715#ixzz3m1SYWNdc>.
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Why Medical Loss Ratio Requirements Aren't a Defense to Further Health Plan Consolidation (Commercial Market)

The Affordable Care Act (ACA) imposes a federal minimum Medical Loss Ratio (MLR) requirement on fully-insured health insurance sold in the individual, small group and large group markets. The MLR is a measure of how much of each premium dollar (less taxes, licensing and regulatory fees) goes to pay for medical claims and activities to improve quality versus plan administration, marketing and insurer profit. The higher the MLR, the more value the policyholder receives for each dollar paid as premium to the insurer. *A minimum MLR standard does not, however, limit the amount of premium that an insurer may charge for its health insurance plans.*

Background. Health insurers are required to publicly report MLRs each year in each state in which they operate. The federal minimum MLR standard for large insured group health insurance is 85 percent; for individual and small group insurance, it is 80 percent.¹ Through 2015, a state may define a large group as one with over 50 members; thereafter, a large group will be defined as having more than 100 members. Insurers of plans that do not meet these minimum required MLR thresholds must rebate excess premium amounts to their policyholders.

These provisions were established by the ACA with the intention of improving the value and transparency of health insurance coverage. As a result of the rebate requirement, consumers in the fully insured commercial market have recouped millions of dollars in excess premiums. However, *administrative and marketing expenses continue to account for a significant portion of premiums.* And despite the application of the MLR requirements and premium rebates beginning in 2011, insurers' profit margins experienced less than a 0.2 percentage point decline between 2011 and 2013, with the losses occurring in the individual market offset by increases in the small and large group markets.² In both 2013 and 2014, the performance of the large national insurers such as Aetna, UnitedHealth and Anthem was favorable, with profit margins exceeding 3.5 percent.³

Moreover, the ACA's MLR standards are not applied to all health coverage. The federal government estimated in 2010 that the MLR standards would protect up to 74.8 million insured Americans,⁴ which was less than 40 percent of people with private health insurance that year.⁵ Plans that are not subject to the MLR requirements include those that are fully- or partially self-insured, which comprise well over 50 percent of private sector employees. Also exempt are dental-only, accident-only and other "excepted benefits," as well as expatriate plans. In addition, a one-year deferral from the MLR is available to insurers that would otherwise be subject to the

MLR limits but have a high proportion of new plans (representing at least half of their business in a given state).⁶

Why the MLR Doesn't Support Further Health Plan Consolidation. The MLR requirements have already surfaced as a defense to the proposed acquisitions of Cigna by Anthem and of Humana by Aetna. The argument to the Department of Justice's Antitrust Division (DOJ) and other federal and state regulators would be that the insurers are constrained from raising prices to consumers because of the MLR margin (profit or net revenue) restrictions applicable in both the commercial and Medicare Advantage markets. This argument is unavailing and should be rejected for the several principle reasons:

1) The ACA's MLR requirements apply to less than 50 percent of Americans under age 65 with health insurance coverage.

As noted above, self-insured (self-funded) health plans, including self-insured association and trust plans, are not subject to the MLR standards, which means that nationwide nearly three out of every five workers are not in plans for which the MLR requirement applies.⁷ Although the rate of self-insurance varies across the 50 states and the District of Columbia, in almost all states, more than 50 percent of private sector employees are covered by self-insured plans that are exempt from the MLR requirements.⁸ Providing administrative services and stop-loss coverage to group health plans sponsored by employers and unions makes up a significant segment of revenues for companies such as Anthem, Aetna, and Cigna. Thus, even if the ACA's MLR requirements acted as some constraint on premiums for their fully insured lines of business, they would be able to raise the fees charged for services provided to self-funded customers. These increased fees would be passed along to employees as increased premiums or cost-sharing.

2) The rules for reporting MLRs provide for a relatively high level of aggregation that may mask wide differences in the return on premium for an insurer's different health insurance products.

The ACA's MLR is not based on each insurer's policy, but on an insurer's annual aggregate performance within each market (individual, small group, or large group) and state. A loss ratio computed separately for an insurer's specific book of business would be subject to more volatility due to unexpected utilization changes than would a measure across the insurer's entire book of business, for example. Yet the broader application of the measure, as required by the ACA's implementing regulations, masks potentially significant variation by market or type of plan. As such, the MLR allows insurers to offer products that do not meet the minimum MLR threshold.

3) The MLR does not address the level of a premium. It only establishes that a minimum percentage of that premium must be used for medical claims and quality enhancing activities.

Here are a few examples of ways that insurers can increase premiums while still meeting existing MLR standards, using an 85 percent illustrative standard and a starting premium of \$1,000. *For simplicity, the example assumes that the MLR is reported for a specific health plan offered by an insurer but as discussed above, in fact, the MLR would be reported across all insured health plans offered by the insurer in its individual, small group or large group markets in a state.*

A. Plan is at MLR in Time 1

In this case, an insurer could raise the plan's premium by any amount. It would, however, need to ensure that the plan maintains its minimum MLR of 85 percent. In this example, it increases its premium by \$100, increasing both its medical claims spending as well as other expenses to continue to comply with the MLR standard.

	Time 1	Time 1 Loss Ratio	Time 2	Time 2 Loss Ratio
Premium	\$1,000		\$1,100	
Payments for medical claims and quality activities	\$850	85%	\$935	85%
All other expenses	\$150		\$165	

B. Plan is above minimum MLR in Time 1

In this case, the plan is not impacted by the minimum MLR, since it already meets the standard. This plan can raise its premium by \$60, potentially keeping all of it as profit, before becoming constrained by the MLR policy.

	Time 1	Time 1 Loss Ratio	Time 2	Time 2 Loss Ratio
Premium	\$1,000		\$1,060	
Payments for medical claims and quality activities	\$900	90%	\$900	85%
All other expenses	\$100		\$160	

C. Plan is below minimum MLR in Time 1

In this case, the plan is not meeting the MLR standard, so it must devote more of its premium to medical claims or quality activities. It can do this by:

- Raising spending on claims until such spending reaches the minimum standard, in this example, by raising premiums by \$335.
- Providing a rebate of \$50 to beneficiaries (the difference between the minimum standard of 85% or \$850 and current spending on claims or \$800), or
- Keeping the premium at its current level, and raising spending on medical claims (for example, by increasing provider payment rates) while simultaneously reducing administrative costs or profit.

	Time 1	Time 1 Loss Ratio	Time 2	Time 2 Loss Ratio
Premium	\$1,000		\$1,335	
Payments for medical claims and quality activities	\$800	75%	\$1,135	85%
All other expenses	\$200		\$200	

The examples illustrate that there are many scenarios in which an insurer can raise rates that are not constrained by the current MLR requirements. A future administration or Congress also could alter the MLR requirements to make it even easier for plans to meet the regulatory criteria and still raise prices for consumers.

¹ Department of Health and Human Services, Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act: Interim Final Rule, *Federal Register*, December 1, 2010. Also note that the ACA gives states flexibility to impose higher minimum MLR requirements. At this point, some states do impose different (more rigorous MLR requirements than apply under federal law and regulations. Congressional Research Service, 2015. Also, HHS may, upon application, adjust the MLR standard in the individual market in a state if the Secretary determines an 80% standard would destabilize the individual market in that state. The Secretary in fact granted waivers to 7 out of 17 states that applied for waivers of the federal MLR standards for their individual markets for the years 2011-2013 on the basis that the federal minimum threshold could lead to de-stabilizing those markets. The states are GA, IA, KY, ME, NE, NH and NC. Department of Health and Human Services, "2011 Issuer MLR Rebate Estimates in States that Applied for an MLR Adjustment," Table of States Requesting Rebates, <http://ccio.cms.gov/programs/marketreforms/mlr/rebateestimates.html>.

² McCue, Michael J. and Mark A. Hall, The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 3, The Commonwealth Fund, March 2015; http://www.commonwealthfund.org/~media/files/publications/issuebrief/2015/mar/1808_mccue_med_loss_ratio_v3_car_3_fb.pdf?la=en

³ Mark Farrah Associates, *Enrollment Gains and Favorable Profits for Health Insurance Leaders in 2014*, May 15, 2015, <http://www.markfarrah.com/healthcare-business-strategy/enrollment-gains-and-favorable-profits-for-health-insurance-leaders-in-2014.aspx>

⁴ Centers for Medicare & Medicaid Services, *Medical Loss Ratio: Getting Your Money's Worth on Health Insurance*, www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/medical-loss-ratio.html; see also the Interim Final Rule impact statement at 75 FR 74896

⁵ Calculated as 74.8 million/Population in 2010 with private health insurance. Percentage of U.S. population with private health insurance from <http://www.census.gov/prod/2011pubs/p60-239.pdf>. Total population from <http://www.census.gov/quickfacts/table/PST045214/00>

⁶ Centers for Medicare & Medicaid Services, Medical Loss Ratio Requirement Under the Patient Protection and Affordable Care Act, Final Rule, May 16, 2012; 77 FR 28790; CMS, CCHIO, *May 24, 2012 FAQ*, <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mlr-guidance-5-24-2012.pdf>

⁷ Kaiser Family Foundation and HRET, *2014 Employer Health Benefits Survey* <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>

⁸ These rates are rounded to the nearest full percentage. AHRQ, Medical Expenditure Panel Survey, Table II.B.2.b.(1)(2014) Percent of private-sector enrollees that are enrolled in self-insured plans at establishments that offer health insurance by firm size and State: United States, 2014, http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2014/t1b2b1.pdf



Why “Rate Review” of Hikes in Health Insurance Isn’t a Defense to Further Health Plan Consolidation (Commercial Market)

States carry out varying degrees of review of health insurers’ rates. Some states review rates and approve them prior to the rates going into effect. Other states require insurers to simply file a rate with the department before the insurer implements it (file and use). Some states have no regulatory oversight of rates at all. The Affordable Care Act (ACA) established a rate review requirement for health insurance products with rate increases of 10 percent or more in a year. **The federal requirement for review does not, however, include the authority to reject rates.** Reviews are conducted either by states or by the federal government through the Department of Health and Human Services (HHS).

Background. The ACA requires that the HHS Secretary, in conjunction with the states, annually review “unreasonable increases in premiums for health insurance coverage.” Rates for health insurance products that increase by 10 percent or more (or exceed a state-specific threshold) must be subject to a review to determine if the rates are excessive, unjustified or unfairly discriminatory.

Forty-four states conduct their own rate reviews. As part of that process, they must post on their websites (or provide links to) rate filings under review or preliminary justifications, seek public comment on proposed rate increases, and report the results of their rate reviews to HHS. States’ reviews may or may not reject excessive rates from being implemented based on whether the state has the authority to disallow them under state law, and whether the state acts on that authority.

In five states, where HHS has determined that there is not an effective rate review program, HHS conducts the review. If HHS finds that a rate increase is unreasonable, it posts that determination on its website and informs the insurer of the determination. The insurer is then required to either notify HHS that it will not implement the rate increase or provide a justification for the rate increase to HHS and post the justification to its website. The carrier could still choose to implement the proposed increase. HHS does not have the authority to disallow it but may take recommendations by state regulators about patterns or practices of excessive or unjustified rate increases into account in determining which plans may be offered as qualified health plans through health insurance exchanges.¹

The rate review requirement applies to all insurance products sold in the individual and small-group markets except for grandfathered health plans. (Small groups for this purpose are defined as those with fewer than 50 employees until 2016 when that threshold rises to 100.)

Why Rate Review Doesn't Support Further Health Plan Consolidation. The rate review requirements could be one of the defenses the insurers' (Anthem/Cigna and/or Aetna/Humana) mount to charges that these acquisitions will provide them with additional market power to increase rates by unreasonable amounts. This defense is unavailing for the simple reason that the ACA's rate review provisions are not effective to prevent unreasonable increases of less than 10 percent, much less those over 10 percent. The weaknesses of the federal rate review process for the commercial market includes the following points:

1. The ACA's rate review requirements apply to a small minority of Americans with private health insurance coverage.

Federal rate review is not universal. It only applies to non-grandfathered plans offered in the small and individual markets and, in most states, to non-association sponsored health plans. In 2011, when HHS issued the final rate review rule, it estimated that 35 million people would be covered by products subject to rate review. In that year, that represented about 17 percent of the commercial market for health insurance.²

2. The federal rate review requirements have limited effectiveness.

The federal requirements do not provide HHS with the authority to reject excessive rates nor to require states to give such authority to their Departments of Insurance. Nor do they pre-empt states' own rate review laws or procedures. As a result, the wide variation in the effectiveness of states' processes has continued post-ACA. For example, state processes continue to vary with respect to the authority each state's law gives the insurance departments to deny or turn back rates.³ As noted above, however, HHS *may* take into account recommendations by state regulators about patterns or practices of excessive or unjustified rate increases in determining which plans will be offered as qualified health plans through exchanges (assuming there is an alternative plan to offer).

3. Even in states that have the authority to reject rate increases, they do not always do so.

The climate in some states may not support strong rate review even if the insurance commissioner/department has the authority to turn back rates.⁴

4. The public disclosure aspect of the rate review process is not fully functioning as intended.

HHS does not have the authority to reject rates; the only influence it may have is to publically pressure insurers to re-evaluate. This dubious strategy assumes a degree of price transparency that is not yet fully operational and may never be. Some states and HHS allow a trade secret exemption for insurers that wish to keep their rates from the public and, as a result of the exemption, HHS withheld 2015 rate filings from public view.⁵ Further, those filings that are publically disclosed are often not easy for consumers to access or understand.

¹ 45 CFR Part 154, Subparts B and C: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016DraftCriteriaIssues12-19-2014.pdf>

² Final Rule with Comment Period: Rate Increase Disclosure and Review, 76 *Federal Register* 29964 - 29988, <http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf>

³ Available at <http://consumersunion.org/wp-content/uploads/2014/04/Exhibit-A-State-List-Public-Participation.pdf>

⁴ <http://www.healthcaredive.com/news/state-rate-regulation-is-there-one-future-or-50/391431/>

⁵ New York Times, Health Insurers Raise Some Rates by Double Digits, January 5, 2013, http://www.nytimes.com/2013/01/06/business/despite-new-health-law-some-see-sharp-rise-in-premiums.html?_r=0

⁶ Health Affairs blog, <http://healthaffairs.org/blog/2014/12/24/health-insurance-rates-setting-trace-to-raise-the-bar-and-lift-the-veil-of-secrecy/>; The Hill, Congress Blog, June 16, 2014 <http://thehill.com/blogs/congress-blog/healthcare/209330-aca-addresses-our-long-history-of-premium-rate-hikes>

Mr. MARINO. Thank you.
Dr. Gurman?

**TESTIMONY OF ANDREW W. GURMAN, M.D.,
PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION**

Dr. GURMAN. Good afternoon. I would like to thank Chairman Marino, Ranking Member Johnson, and the Subcommittee for inviting us to participate in this oversight hearing on health insurance mergers and their impact on competition.

Physicians want to participate in a health care delivery system that allows us to deliver high-quality and efficient care to our patients. We believe that competition is an excellent prescription for achieving that goal. Competition among health insurers can lower premiums, enhance customer service, and spur innovative ways to improve quality while lowering costs. Patients benefit when they can choose from an array of insurers who compete for their business by offering desirable coverage at affordable prices.

Consolidation, on the other hand, compromises the ability of physicians to advocate for their patients. In practice, market power allows insurers to exert control over clinical decisions, which undermines the doctor-patient relationship and eliminates crucial safeguards of patient care.

This underscores what ultimately is at stake here—the health and safety of America’s patients.

Our annual study of commercial health insurance markets, which was provided to you, utilizes metrics set by the Department of Justice and the Federal Trade Commission to classify market concentration. The results point to a near total absence of competition among health insurers with 70 percent of markets rated as highly concentrated.

Meanwhile, a recent Commonwealth Fund study indicates that competitive conditions in Medicare Advantage markets are even more dire. And in the national market where large employers purchase coverage, the proposed mergers being examined today would pare the five national players down to three.

We believe that there must be a rigorous review of proposed mergers according to the federally established standards to determine their effects on competition and their consequences for patient care.

In 2010, the DOJ found that the proposed Blue Cross merger in Michigan would have resulted in “the ability to control physician reimbursement rates in a manner that could harm the quality of health care delivered to consumers.” The same analysis should be applied to pending mergers.

Competition, not consolidation, has been shown time and again to benefit patients. One study found that increased competition among insurers was associated with more generous prescription drug benefits.

According to several studies, past mergers led to increased health insurance premiums. In the wake of a 2008 merger in Nevada, premiums spiked by almost 14 percent. “If past is prologue”, notes Professor Leemore Dafny, “consumers can expect higher insurance premiums” due to consolidation.

Irrespective of premium hikes, lower physician rates in and of themselves can also harm patients by artificially degrading available care. This is the essence of monopsony power, whereby market control suppresses the quality or quantity of services.

Our analysis of the commercial market share effects of the proposed megamergers reveal that they would enhance market power in as many as 97 metropolitan areas within 17 States. The Anthem-Cigna merger alone would enhance market power in 85 metropolitan areas within 13 States, while the Aetna-Humana merger would combine two of the four largest Medicare Advantage insurers to form the largest such entity in the country. This is in addition to the impact on the national market if the so-called big five becomes the big three.

We are at a critical decision point on health insurance mergers because, once consummated, there is simply no going back. Post-merger remedies are likely to be both ineffective and highly disruptive. You cannot unscramble an egg.

Thus, we believe that the time for heightened scrutiny and careful consideration is now, before proposed mergers take effect and patients are irreparably harmed.

The solution lies in more, not less, competition. It begins by recognizing that coordinated care does not require massive consolidation. The good news is that there are steps that regulators and lawmakers can take right now to ease barriers and foster competition. These include facilitating new entry into hospital markets and eliminating program integrity and antitrust roadblocks to physician innovation.

We look forward to working with the Subcommittee to advance a vision for the future of American medicine in which competition, when allowed to flourish, can promote the delivery of high-quality, cost-effective care.

Thank you, sir, and thank you to the Committee for your continued efforts on this issue. And I have to tell you, having first visited this Congress as a 10-year-old schoolboy, what a thrill it is for me to be here today. Thank you so much.

[The prepared statement of Dr. Gurman follows:]



TESTIMONY

of the

American Medical Association

before the

Committee on the Judiciary

**Subcommittee on Regulatory Reform, Commercial and Antitrust
Law**

**RE: Healthy Competition? An Examination of the Proposed
Health Insurance Mergers and the Consequent Impact on
Competition**

Presented by: Andrew W. Gurman, MD

September 29, 2015

Division of Legislative Counsel

202-789-7426

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Presented by: Andrew W. Gurman, MD

September 29, 2015

The American Medical Association (AMA) appreciates the opportunity to provide our views regarding today's hearing on competition in health insurance markets and the consequences of further consolidation. We commend Chairman Marino and Members of the Subcommittee for addressing these important antitrust issues. Our comments examine the impact of health insurer consolidation on patient care, the analysis of data related to the two proposed mergers among national health insurance companies, and a vision for the future of the health care marketplace in which competition, if allowed to flourish, can promote the delivery of high quality, cost-effective health care. We believe that there must be a rigorous review of proposed mergers—in accordance with metrics established by the U.S. Department of Justice (DOJ) and Federal Trade Commission (FTC)—to determine their effects on competition and their consequences for consumers and health care providers. We therefore urge federal and state regulators to carefully scrutinize the announced health insurer mergers for compliance with Agency guidelines and to utilize available enforcement tools to preserve competition for the benefit of Americans' physical and fiscal health.

THE CURRENT STATE: HIGH CONCENTRATION OF HEALTH INSURANCE MARKETS

The AMA believes that competition, not consolidation, is the right prescription for health insurance markets. Competition can lower premiums and incentivize insurers to enhance customer service, pay bills accurately and on time, and develop and implement innovative ways to improve quality while lowering costs. Competition also allows physicians to bargain for contract terms that touch all aspects of patient care. This is critical because practicing physicians' overarching aim to provide the best care for their patients can be frustrated when

insurers exert clinical pressures and compromise the health care decision-making that lies at the heart of the doctor-patient relationship.¹

Competition is likely to be greatest when there are many sellers, none of which having any significant market share. Unfortunately health insurance markets are already mostly highly concentrated, meaning that typically there are few sellers and they possess significant market shares. Thus, most health insurance markets are no longer competitive, while the national market in which large employers purchase coverage is also shrinking.

For the past 14 years, the AMA has conducted the most in-depth annual study of commercial health insurance markets in the country. Our study utilizes the DOJ and FTC Horizontal Merger Guidelines (2010) (Merger Guidelines) to classify market concentration in metropolitan statistical areas (MSAs) and states.² The AMA's most recently published study, *Competition in Health Insurance: a Comprehensive Study of US Markets* (2015 update), is intended to help researchers, policymakers, and federal and state regulators identify areas of the country where consolidation among health insurers may have harmful effects on consumers, on providers of care, and on the economy. The AMA's analysis shows that there has been a near total collapse of competition among health insurers, with seven out of ten MSAs rated as highly concentrated based on the Merger Guidelines used to assess market competition. Moreover, 38 percent of MSAs had a single health insurer with a commercial market share of 50 percent or more. Fourteen states had a single health insurer with at least a 50 percent share of the commercial health insurance market, while 46 states had two health insurers with at least a 50 percent share of the commercial health insurance market.

The AMA's study does not cover Medicare Advantage markets. However, competitive conditions there appear to be even more troubling than in the commercial health insurance market. According to a Commonwealth Fund study published last month, 97 percent of Medicare Advantage markets are highly concentrated and therefore characterized by a lack of competition.³

DETRIMENTAL EFFECTS FOR CONSUMERS ON COVERAGE AND CARE

High insurer market concentration is an important issue of public policy because the anticompetitive effects of insurers' exercise of market power poses a substantial risk of harm to consumers. Given the present structure of the health insurance market, health insurers have the

¹ Judy Packer-Turman, "The Fight For Clinical Control," *Medical Economics* (November 21, 2014), available at: <http://medicaleconomics.modernmedicine.com/medical-economics/news/fight-clinical-control?page=full>.

² U.S. Dep't of Justice and Fed. Trade Comm'n, Horizontal Merger Guidelines (Aug. 19, 2010), available at: <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>.

³ B. Biles, G. Casillas, and S. Guterman, *Competition Among Medicare's Private Health Plans: Does It Really Exist?* The Commonwealth Fund, August 2015.

ability—unilaterally or through coordinated interaction—to exercise market power by raising premiums, reducing service, or stifling innovation. Accordingly, health insurance markets require more, not less, competition. Mergers must therefore be carefully scrutinized using the metrics established by the DOJ and FTC.

Monopsony Power Can Harm Health Care Access and Quality

The unprecedented lack of competition that already exists in most health insurance markets exerts adverse pressure on the ability of physicians to advocate for their patients, which is a crucial safeguard of patient care. When one or more health insurers dominate a market, physicians who engage in aggressive patient advocacy risk exclusion from the dominant insurers' networks, compromising the financial viability of their practices. Mergers may also cause even tighter provider networks, which mean that patients are more likely to encounter physicians who are outside their network and thereby incur higher out-of-pocket costs. While the relationship between insurer consolidation and plan quality requires additional research, one study in the Medicare Advantage market found that more robust competition was associated with greater availability of prescription drug benefits.⁴ As Professor Leemore Dafny observes, "the competitive mechanisms linking diminished competition to higher prices operate similarly with respect to lower quality."⁵

Moreover, physicians cannot adequately address their patient access, quality of care, and patient advocacy concerns through negotiation, since they typically stand at a significant competitive disadvantage with respect to health insurers. In a Policy Research Perspective published in July 2015, the AMA found that the majority (60.7 percent) of physicians still work in small practices with 10 or fewer physicians.⁶ Most physicians, therefore, lack the leverage to be equal negotiating partners with dominant insurers to advocate for and promote patient care.

Dominant health insurers can also use their market power to pay physicians below competitive levels, which can undermine both access to and quality of care. We believe that the DOJ, FTC, and state attorneys general should closely scrutinize any health insurer merger where the merged entity would likely be able to lower reimbursement rates for physicians and other providers below competitive levels, which would result in a reduction in the quality or quantity of services offered to patients. The DOJ has successfully challenged two health insurer mergers (half of all cases brought against health insurer mergers) based in part on DOJ claims that the merger would

⁴ See R. Town and S. Liu (2003), "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* 34(4): 719-36.

⁵ Leemore S. Dafny, PhD, Testimony Before the Senate Committee on the Judiciary (September 22, 2015), available at: <http://www.judiciary.senate.gov/download/09-22-15-dafny-testimony-updated>.

⁶ Carol Kane, "Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership," *Policy Research Perspectives*, 2015-3, available at: <https://download.ama-assn.org/resources/doc/health-policy/x-pub/prp-practice-arrangement-2015.pdf>.

have anticompetitive effects in the purchase of physician services. These challenges occurred in the merger of Aetna and Prudential in Texas in 1999,⁷ and the merger of United Health and PacifiCare in Tucson, Arizona and in Boulder, Colorado in 2005.⁸ In a third merger matter occurring in 2010 between Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan, those health insurers abandoned their merger plans when the DOJ announced that it would file an antitrust lawsuit to block the acquisition. The DOJ argued that the merger “would have given Blue Cross Michigan the ability to control physician reimbursement rates in a manner that could harm the quality of healthcare delivered to consumers.”⁹

DOJ’s monopsony challenges specifically noted that inadequate physician payment can harm health care quality. The Agency’s actions properly reflected its conclusion that it is a mistake to assume that a health insurer driving down medical fees, in the exercise of monopsony power, is a good thing for consumers. This was also the well-documented conclusion reached in the 2008 hearings before the Pennsylvania Insurance Department on the competition ramifications of the proposed merger between Highmark, Inc. and Independence Blue Cross. The Pennsylvania Insurance Department noted that “competition between Highmark and Capital Blue Cross” in central Pennsylvania “has been good for providers and good for consumers.”¹⁰ Based on an extensive record of nearly 50,000 pages of expert and other commentary,¹¹ the Department was prepared to find the proposed merger to be anticompetitive in large part because it would have granted the merged health insurer undue leverage over physicians and other health care providers.¹² Consumers do best when there is a competitive market among health care purchasers.

Indeed, there may be antitrust concerns if a health insurer can lower compensation to physicians, even if it cannot raise premiums for patients. Hence in the United/PacifiCare merger, the DOJ required a divestiture based on monopsony concerns in Boulder, Colorado, even though United/PacifiCare would not necessarily have had market power in the sale of health insurance. The reason is straightforward: the reduction in compensation would lead to diminished service and quality of care, which harms consumers even though the direct prices paid by subscribers do

⁷ *U.S. v. Aetna Inc.*, No. 3-99CV 1398-H, ¶¶ 17-18 (June 21, 1999) (complaint), available at: <http://www.usdoj.gov/atr/cases/t2500/2501.pdf>, see also *U.S. v. Aetna, Inc.*, No. 3-99 CV 1398-LL, at 5-6 (Aug. 3, 1999) (revised competitive impact statement), available at: <http://www.usdoj.gov/atr/cases/t2600/2648.pdf>.

⁸ *U.S. v. United Health Group Inc.* No. 1:05CV02436 (D.D.C., Dec. 20, 2005) (complaint), available at: www.usdoj.gov/atr/cases/t213800/213815.htm.

⁹ Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans | OPA | Department of Justice, available at: <http://www.justice.gov/opa/pr/blue-cross-blue-shield-michigan-and-physicians-health-plan-mid-michigan-abandon-merger-plans>.

¹⁰ Statement of Pennsylvania Insurance Commissioner Joel Ario on Highmark and IBC Consolidation (January 22, 2009).

¹¹ See background information, including excerpts from the experts, available at:

http://www.ins.state.pa.us/ins/lib/ins/whats_new/Excerpts_from_PA_Insurance_Dept_Expert_Reports.pdf.

¹² The merger was abandoned by those insurers because the Department insisted that one of them drop its Blues brand. The parties refused and instead called it off.

not increase.¹³ For example, compensation below competitive levels hinders physicians' ability to invest in new equipment, technology, training, staff, and other practice infrastructure that could improve the access to, and quality of, patient care. It may also force physicians to spend less time with patients to meet practice expenses. The exercise of monopsony power threatens consumers by enabling a dominant insurer to "force doctors and hospitals to go beyond trimming costs, to cut costs so far that it begins to degrade the care and service they provide below what consumers value and need."¹⁴

Such reduction in service levels and quality of care causes immediate harm to consumers. In the long run, it is imperative to consider whether monopsony power will further harm consumers by driving physicians from the market. Irrespective of premiums, slashing provider rates can "harm consumers directly," because the very nature of monopsony is that it reduces quantity or quality below "socially optimal" levels.¹⁵ Health insurer payments that are below competitive levels may reduce patient care and access by motivating physicians to retire early or seek opportunities outside of medicine that are more rewarding, financially or otherwise. According to a 2015 study released by the Association of American Medical Colleges, the U.S. will face a shortage of between 46,000-90,000 physicians by 2025. The study, which is the first comprehensive national analysis that takes into account both demographics and recent changes to care delivery and payment methods, projects shortages in both primary and specialty care.¹⁶ Recent projections by the Health Resources and Services Administration similarly suggest a significant shortage of primary care physicians in the United States.¹⁷

Moreover, according to a recent survey by Deloitte, six in 10 physicians said it was likely that many physicians would retire earlier than planned in the next one to three years, a perception that Deloitte stated is fairly uniform among all physicians, irrespective of age, gender, or medical specialty.¹⁸ According to the Deloitte survey, 57 percent of physicians also said that the practice of medicine was in jeopardy and nearly 75 percent of physicians thought that the "best and the brightest" may not consider a career in medicine. Finally, most physicians surveyed believed

¹³ See Gregory J. Werden, *Monopsony and the Sherman Act: Consumer Welfare in a New Light*, 74 ANTITRUST L.J. 707 (2007) (explaining reasons to challenge monopsony power even where there is no immediate impact on consumers); Marius Schwartz, *Buyer Power Concerns and the Aetna-Prudential Merger*, Address before the 5th Annual Health Care Antitrust Forum at Northwestern University School of Law, at 4-6 (October 20, 1999) (noting that anticompetitive effects can occur even if the conduct does not adversely affect the ultimate consumers who purchase the end-product), available at: <http://www.usdoj.gov/atr/public/speeches/3924.wpd>.

¹⁴ Statement of George Slover, Senior Policy Counsel, Consumers Union, Hearing of the Senate Committee on the Judiciary (September 22, 2015), available at: <http://www.judiciary.senate.gov/meetings/examining-consolidation-in-the-health-insurance-industry-and-its-impact-on-consumers>.

¹⁵ Dafny, Testimony Before the Senate Committee on the Judiciary (September 22, 2015), available at:

<http://www.judiciary.senate.gov/download/09-22-15-dafny-testimony-updated>.

¹⁶ See IHS Inc., *The Complexities of Physician Supply and Demand: Projections from 2013 to 2025* (Prepared for the Association of American Medical Colleges, 2015).

¹⁷ See Health Resources and Services Administration, "Projecting the Supply and Demand for Primary Care Physicians through 2020 in brief" (November 2013).

¹⁸ Deloitte 2013 Survey of U.S. Physicians: Physician perspectives about health care reform in the future of the medical profession.

that physicians would retire or scale back practice hours, based on how the future of medicine is changing.¹⁹ Further impetus for physicians to work less, leave practice, or retire early may compromise patient access to care. Indeed, recent research finds evidence that insurer consolidation leads to the exercise of monopsony power in physician markets, resulting in prices paid to physicians that are below competitive levels and thereby reducing the quantity or quality of health care, which harms consumers.²⁰

Past Consolidation Has Led to Premium Increases for Consumers

A growing body of peer-reviewed literature suggests that greater consolidation leads to price increases, as opposed to greater efficiency or lower health care costs. In other words, alleged “savings” generated from lower provider reimbursement is not passed on to either patients or employers. “If past is prologue,” notes Professor Dafny, “insurance consolidation will tend to lead to lower payments to healthcare providers, but those lower payments will not be passed on to consumers. On the contrary, consumers can expect higher insurance premiums.”²¹

Insurers’ interests are not perfectly aligned with those of consumers. Health insurer monopsonists typically are also monopolists. Therefore, their lower input prices (for physician services) do not necessarily lead to lower consumer output prices (i.e., health insurance premiums).²² In 2008, the Pennsylvania Insurance Department stated that its “nationally renowned economic expert, LECG, rejected the idea that using market leverage to reduce provider reimbursements below competitive levels will translate into lower premiums, calling this an ‘economic fallacy’ and noting that the clear weight of economic opinion is that consumers do best when there is a competitive market for purchasing provider services.”²³ Highly concentrated health insurer markets limit patient choice by forcing them to receive their health care coverage from just one or two dominant players and accept watered-down benefits. This allows insurers to dictate important aspects of patient care, as opposed to patients electing treatment in consultation with their health care professionals.

The need for merger antitrust scrutiny is illustrated by the evidence concerning the effects of past health insurance mergers on premiums. For example, a study of the 1999 merger between Aetna and Prudential found that the increased market concentration was associated with higher premiums.²⁴ More recently, a second study examined the premium impact of the 2008 merger

¹⁹ *Id.*

²⁰ See Dafny et al., “Paying a Premium on your Premium? Consolidation in the US Health Insurance Industry,” *American Economic Review* 2012; 102: 1161-1185.

²¹ *Id.*

²² Peter J. Hammer and William M. Sage, *Monopsony as an Agency and Regulatory Problem in Health Care*, 71 ANTITRUST L.J. 949 (2004).

²³ Statement of Pennsylvania Insurance Commissioner Joel Ario on Highmark and ILC Consolidation (January 22, 2009).

²⁴ Dafny et al., “Paying a Premium on your Premium? Consolidation in the US Health Insurance Industry,” *American Economic Review* 2012; 102: 1161-1185.

between UnitedHealth Group and Sierra Health Services. That merger led to a large increase in concentration in Nevada health insurance markets. The study concluded that in the wake of the merger, premiums in Nevada markets increased by almost 14 percent relative to a control group. These findings suggest that the merging parties exploited their resulting market power, to the detriment of consumers.²⁵

Competition among health insurers, on the other hand, has been found to be associated with lower premiums. Research suggests that on the federal health insurance exchanges, the participation of one new carrier (UnitedHealthcare) would have reduced premiums by 5.4 percent, while the inclusion of all companies in the individual insurance markets could have lowered rates by 11.1 percent.²⁶

PROPOSED HEALTH INSURER MERGERS: CONSOLIDATING THE CONSOLIDATED

The current proposals to reduce the five national health insurers to just three should be viewed in light of current conditions, as they threaten to exacerbate the near total collapse of competition among health insurers in most markets. According to AMA analyses of the proposed mergers, which are attached to this testimony, the combined impact of the two mergers would exceed the Merger Guidelines by enhancing market power in as many as 97 MSAs within 17 states. Taking into account those markets where the mergers would raise significant competitive concerns, the two mergers would diminish competition in up to 154 MSAs within 23 states.

The AMA's state-level analysis shows the proposed Anthem-Cigna merger would be presumed likely to enhance market power under the Merger Guidelines in the commercial, combined HMO+PPO+POS markets in 10 of the 14 states (NH, IN, CT, ME, VA, GA, CO, MO NV, KY) in which Anthem is licensed to provide commercial coverage. In the remaining four "Anthem" states (OH, CA, NY, WI), the merger would potentially raise significant competitive concerns and warrant scrutiny under the Merger Guidelines. The MSA-level analysis indicates the Anthem-Cigna merger alone would enhance market power in 85 MSAs within 13 states, and would diminish competition in up to 111 MSAs within all 14 states where Anthem offers commercial coverage.

A closer look at the Aetna-Humana merger shows that it would enhance market power in 15 MSAs within 7 states (FL, GA, IL, KY, OH, TX, UT). All told, the merger would diminish competition in up to 58 MSAs within 14 states. Moreover, the proposed merger of Humana and

²⁵ Jose R. Guardado, David W. Emmons, and Carol K. Kane, "The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra" *Health Management, Policy and Innovation* 2013; 1(3) 16-35.

²⁶ Dafny et al., "More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces," *American Journal of Health Economics* 2015; 1(1): 53-81. See also "More Insurers, Lower Premiums? Evidence from Initial Pricing in the Health Insurance Marketplaces," *Kellogg Insight* (July 7, 2014), http://insight.kellogg.northwestern.edu/article/more_insurers_lower_premiums.

Aetna would combine one of the two largest insurers of Medicare Advantage (Humana) with the fourth largest (Aetna) to form the largest Medicare Advantage insurer in the country.²⁷

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

The Need for Antitrust Scrutiny of Health Insurer Mergers

Based on past experience, the AMA believes it is critical that the DOJ, FTC, and state attorneys general carefully consider the consequences of the proposed megamergers in the health insurance industry. Specifically, we believe it is important to evaluate the potential effects on both (1) the sale of health insurance products to employers and individuals (the sell side), and (2) the purchase of health care provider (e.g., physician) services (the buy side).²⁸ The proposed megamergers may pose a threat of anticompetitive effects in both the local and national markets in which individuals and employers purchase insurance. The mergers also could enable the merged entities to lower reimbursement rates for physicians such that there would be a reduction in the quality or quantity of the services that physicians are able to offer patients.

We believe that the DOJ, FTC, and state attorneys general should also examine the proposed megamergers for their potential effects in the markets for Medicare Advantage. In performing that analysis, federal and state regulators should scrutinize the claims of merger proponents that the mergers would not be problematic in the Medicare Advantage market because consumers have the option of enrolling in traditional Medicare. In prior mergers of insurers offering Medicare Advantage plans, the DOJ has determined that traditional Medicare is not an equal substitute for Medicare Advantage primarily because Medicare Advantage plans offer substantially richer benefits at lower costs than traditional Medicare.²⁹ Moreover, the Agency has found that seniors would not likely switch away from Medicare Advantage plans to traditional Medicare to defeat an anticompetitive Medicare Advantage price increase. These conclusions are bolstered by research to the effect that Medicare is not an equal substitute for Medicare Advantage. The programs constitute separate and distinct product markets, such that

²⁷ 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/>.

²⁸ *U.S. v. Aetna Inc.*, No. 3-99CV 1398-H, ¶¶ 17-18 (June 21, 1999) (complaint), available at: <http://www.usdoj.gov/atr/cases/f2500/2501.pdf>; *U.S. v. United Health Group Inc.* No. 1:05CV02436 (D.D.C., Dec. 20, 2005) (complaint), available at: www.usdoj.gov/atr/cases/f213800/213815.htm.

²⁹ See *U.S. v. United Health Group and Sierra Health Services Inc.*, Civil No. 1:08-cv-00322 (DDC2008); *United States v. Humana*, No. 12-cv-00464 (D.D.C. Mar. 27, 2012), available at: www.justice.gov/atr/cases/f281600/281618.pdf.

the proposed mergers should be evaluated for their effects in the Medicare Advantage market.³⁰ The closest competition to one Medicare managed care plan is another Medicare managed care plan. Thus, it is the presence of many competing managed care plans that keeps the Medicare Advantage market competitive.³¹

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

Given the troubling absence of competition in health insurance markets, the AMA believes federal and state regulators should redouble their efforts in preventing anticompetitive health insurance mergers. While there have been hundreds of mergers involving health insurers and managed care organizations, the DOJ has never fully litigated a single challenge to a health insurer merger. It has, however, challenged four such mergers and settled them through consent decrees.³² In a fifth case, the health insurers abandoned their planned merger when DOJ advised them that it would challenge the transaction.³³

Barriers to Entry and the Permanence of Lost Competition

Lost competition through a merger of health insurers is likely to be permanent, and acquired health insurer market power would be durable, because barriers to entry prevent new entrants from restoring competition in concentrated markets. These barriers include state regulatory

³⁰ R. Town and S. Liu, (2003), "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* 34(4): 719-36; I. Dafny and D. Dranove (2008), "Do Report Cards Tell Consumers Anything They Don't Already Know?" *RAND Journal of Economics* 39.

³¹ See *U.S. v. United Health Group and Sierra Health Services Inc.*, Civil No.1:08-cv-00322 (D.D.C.2008) (the DOJ alleged that MA is a distinct market separate from the Medicare market and obtained a consent decree requiring the divestiture of United's MA business in the Las Vegas area as a precondition to obtaining merger approval); see also Gretchen A. Jacobson, Patricia Neuman, Anthony Damico, "At Least Half Of New Medicare Advantage Enrollees Had Switched From Traditional Medicare During 2006-11," *34 Health Affairs* (Millwood) 48, 51 (Jan. 2015), available at: <http://content.healthaffairs.org/content/34/1/48.full.pdf>.

³² Humana's acquisition of Arcadian management services in 2012 (Humana/Arcadian); United Health Group's acquisition of Sierra Health in 2008 (United Sierra); United Health Group's acquisition of Pacific Care in 2006 (United/Pacific Care); and Aetna's acquisition of Prudential in 1999 (United/Prudential). Humana/Arcadian and United/Sierra concerned the Medicare Advantage markets, while United/Pacific Care and Aetna/Prudential focused on the commercial health insurance markets. See *U.S. v. Humana*, No. 12-cv-00464 (D.D.C. Mar. 27, 2012), available at: www.justice.gov/atr/cases/f281600/281618.pdf; *U.S. v. UnitedHealth Grp., Inc.*, No. 08-cv-00322 (D.D.C. Feb. 25, 2008), available at: www.justice.gov/atr/cases/f230400/230447.htm; *U.S. v. UnitedHealth Grp., Inc.*, No. 05-cv-02436 (D.D.C. Dec. 20, 2005) (UnitedHealth Group Complaint), available at: www.justice.gov/atr/cases/f213800/213815.htm; *U.S. v. Aetna, Inc.*, No. 99-cv-398-11 (N.D. Tex. June 21, 1999), available at: www.justice.gov/atr/cases/f2500/2501.htm.

³³ See DOJ press release, Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans, available at: <http://www.justice.gov/opa/pr/blue-cross-blue-shield-michigan-and-physicians-health-plan-mid-michigan-abandon-merger-plans>.

requirements; the need for sufficient business to permit the spreading of risk; contending with established insurance companies that have built long-term relationships with employers and other consumers; developing a health care provider network; and overcoming the brand-name acceptance of established insurers.³⁴

Moreover, a reason for the discussed health insurer merger proposals to receive a heightened level of scrutiny before they take effect is that a post-merger remedy, such as divestiture, could be highly disruptive to the marketplace and cause harm to consumers. As such, the remedy of divestiture in a health insurer merger case is problematic. The would-be purchaser of the divested business would need to be able to offer a provider network at a cost and quality comparable to that of the merger parties. Given the barriers to entry to health insurance markets, such a qualified purchaser, if found, would likely already be a market participant and a divestiture to such an existing market participant would not likely return the market to even pre-merger levels of competition.

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

The Right Prescription for Health Insurance Markets: More Competition, Not Less

One stated rationale for the health insurer megamergers now proposed is that the mergers are needed to generate efficiencies that will ultimately benefit consumers. That claim is refuted by the studies of consummated health insurance mergers, which show that the mergers actually resulted in higher, not lower, insurance premiums. This finding is logically explained by the fact that post-merger, health insurers lose the incentive to pass along cost savings to consumers, both because they face little competition and because the demand for health insurance is inelastic—when the price is raised, the insurer's total revenue increases, and when price falls so do total revenues.³⁵

³⁴ See Robert W. McCann, *Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field,"* HEALTH L. HANDBOOK (Thomson West 2007); Mark V. Pauly, *Competition in Health Insurance Markets*, 51 L. & CONTEMP. PROBS. 237 (1988); Federal Trade Comm'n and U.S. Dep't of Justice, *Improving Health Care: A Dose of Competition* (July 2004); *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 L. & CONTEMP. PROBS. 195 (1988); 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), available at: <http://www.justice.gov/atr/speech/competition-and-health-care-prescription-high-quality-affordable-care>.

³⁵ 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 (Mathematica Policy Research Ref. No. 6203-042, 2006), available at: <http://www.mathematica-mpr.com/publications/pdfs/priceincome.pdf>.

Several scholars have argued that one of the motivations for the health insurer mergers is to respond to hospital consolidation.³⁶ In this view, the hospital community has responded to the call for more integrated care by consolidating and acquiring market power and thus health insurers have the need to acquire countervailing power. There is, however, no economic evidence that the formation of bilateral hospital/health insurer monopolies—a battle between proverbial Sumo wrestlers—benefits consumers. Professor Thomas Greaney observes that such matches often end in a handshake and consumers get crushed.³⁷ According to Greaney, the theory that enabling dominant insurers to counter dominant hospitals will benefit consumers is a “fallacy.”³⁸ The better answer to hospital consolidation is to recognize that integrated care does not necessarily require hospital-led consolidation and that by encouraging entry into hospital markets, hospital markets can be made competitive.

AN ALTERNATIVE VISION: FOSTERING COMPETITION IN HEALTH CARE

Many hospital markets are already highly concentrated and noncompetitive.³⁹ Moreover, embedded hospital market concentration is fast becoming an intractable problem for which antitrust provides no remedy.⁴⁰ Fortunately, regulators can take steps to encourage new entry.⁴¹ Low-hanging fruit in this area would be removing barriers to health care market entry that the government itself has erected. These include more flexible antitrust enforcement policies to foster physician networks engaged in alternative payment models (APMs), as well as the elimination of state certificate of need (CON) laws and the ban on physician-owned specialty hospitals (POHs).

The AMA, like the FTC and the DOJ, has long advocated for the abolishment of CON. Some progress has been made as 14 states have discontinued their CON programs. Thirty-six states, however, currently maintain some form of CON program.⁴² Numerous studies have shown that CON laws have failed to achieve their intended goal of containing costs.⁴³ Instead, CON has taken on particular importance as a way to claim territory and to restrict the entry of new

³⁶ See “Health Care Management Professor Mark Pauly PhD Discusses Proposed Health Care Insurance Company Mergers,” available at: <http://knowledge.wharton.upenn.edu/article/whats-driving-health-insurers-merger-mania/>; Greaney, “Examining Implications of Health Insurance Mergers,” available at: <http://healthaffairs.org/blog/2015/07/16/examining-implications-of-health-insurance-mergers/>.

³⁷ Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 OR. L. REV. 811 (2011).

³⁸ Greaney, Testimony Before the House Committee on the Judiciary (September 10, 2015), available at: http://judiciary.house.gov/index.cfm/hearings?id=417B9162-C1B8D-41C7-905D-401391B9115L7&Statement_id=16324A0C-5B30-46E2-976F-41DCC05F8EDE.

³⁹ See Martin Gaynor and Robert Town, *The Impact of Hospital Consolidation—Update, the Synthesis Project*, Robert Wood Johnson Foundation (June 2012).

⁴⁰ See e.g., Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 OR. L. REV. 811 (2011).

⁴¹ (“Antitrust does not break up legally acquired monopolies or oligopolies.”).

⁴² *Id.*

⁴³ See National Conference of State Legislatures, Certificate of Need: State Health Laws and Programs (July 2014), available at: <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>.

⁴⁴ See Michael A. Morissey, *State Health Care Reform: Protecting the Provider*, in *American Health Care: Government, Market Processes, and the Public Interest*, at 243-66 (Roger D. Feldman ed., Transaction Publishers 2000).

competitors.⁴⁴ By restricting the entry of competitors, such as physician-owned facilities, CON laws have weakened the markets' ability to contain health care costs, undercut consumer choice, and stifled innovation. Thus, the AMA urges the FTC and the DOJ to redouble their efforts in advocating for the repeal of CON laws.

Unfortunately, provisions within section 6001 of the Affordable Care Act (ACA) "essentially create a federal certificate of need requirement" for POHs.⁴⁵ First, section 6001 eliminates the Stark exception for physicians who do not have an ownership or investment interest and a provider agreement in effect as of December 31, 2010. Second, the POH cannot expand its treatment capacity unless certain restrictive exceptions can be met. Thus, as Professor Greaney observes, "the ACA all but put an end to one source of new competition in hospital markets by banning new physician-owned hospitals that depend on Medicare reimbursement."⁴⁶

The lost source of competition is especially missed because POHs have developed an enviable track record for high quality and low cost care. According to CMS, specialty hospitals offer very high patient satisfaction and high quality of care.⁴⁷ Nine of the top 10 performing U.S. hospitals listed in late 2012 by CMS were POHs. Of the 238 POHs in the U.S., 48 were ranked in the top 100.⁴⁸ Lifting the ban on POHs could raise the performance of the entire hospital market. The market entry of POHs would induce incumbent community hospitals to attempt to "meet the competition" in inpatient services by extending patient hours, improving scheduling, and upgrading equipment.⁴⁹

In a similar vein, rather than accepting the continued breakdown of health insurer competition as inevitable, we believe that lawmakers and regulators can help promote beneficial competition by breaking down barriers to entry and coordination of care. There are ways to achieve the coordinated care that patients desire without succumbing to payer dominance that yields higher premiums, lower quality, and reduced access. The AMA strongly supports and encourages competition between and among health care providers, facilities, and insurers as a means of promoting the delivery of high quality, cost-effective health care. Providing patients with more choices for health care services and coverage stimulates innovation and incentivizes improved care, lower costs, and expanded access.

⁴⁴ *Id.*; Tracy Yee et al., *Health Care Certificate-of-Need Laws: Policy or Politics*, Research Brief 4, National Institute for Health Care Reform (May 2011).

⁴⁵ 42 USC 1395nn; Joshua Perry, *An Obituary for Physician-Owned Specialty Hospitals*, 23(2) HEALTH LAWYER 24 (American Bar Association, December 2010).

⁴⁶ Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 OR. L. REV. at 841 (2011).

⁴⁷ Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, pp 36-55 (CMS Report), available at: <http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf>.

⁴⁸ See American Medical News (April 29, 2013).

⁴⁹ Medicare Payment Advisory Commission, Report to the Congress: Physician-Owned Specialty Hospitals (March 2005) at 10, available at: http://medpac.gov/documents/reports/Mar05_SpecHospitals.

In keeping with this commitment, the AMA has long advocated for physician leadership in new payment and delivery models that focus on quality and efficiency. We believe that physician leadership in these new models is imperative to their success, and offers the greatest potential both to protect patients' interests and to incur lower costs.

Eliminating Antitrust and Program Integrity Barriers to Physician Innovation

To promote greater physician participation in APMs, especially by small and specialty practices, we believe the legal and regulatory framework for new care models must allow and encourage flexibility. Under antitrust law, physicians generally may not collaborate regarding payer negotiations unless they are integrated, either financially or clinically. While some innovative delivery systems have sought and obtained conditional antitrust clearance from the FTC pursuant to a showing that they are clinically integrated, the current enforcement policies regarding physician network joint ventures are unnecessarily restrictive, require costly complex infrastructure, and are ultimately prohibitive to physician participation in new delivery models.⁵⁰ This rigidity may prevent physicians from leading APMs and producing the considerable benefits that would otherwise accrue, leaving hospitals and very large health systems as the only players in the market.

The FTC and DOJ have recognized this problem and provided some much-needed relief by clarifying the application of antitrust laws to accountable care organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP).⁵¹ The AMA strongly supports this effort and encourages the FTC and DOJ to consider additional clarifying guidance for other models, especially those developed by the Center for Medicare and Medicaid Innovation (CMMI). Clear and commonsense antitrust rules concerning the formation of innovative delivery models can enable physicians to pursue integration options that are not hospital driven.

We also believe that clarification of program integrity laws would help promote innovative arrangements that pose little risk of fraud and abuse, especially the overly broad prohibition against gainsharing arrangements. Allowing more flexibility in gainsharing arrangements could promote APMs that provide cost savings and improve efficiency. We urge Congress and the Agencies to examine ways to modernize existing laws and requirements to reflect a more coordinated approach to delivering care. Physician leadership in efforts to align payment with quality is instrumental to optimizing care, improving population health, and reducing costs.

⁵⁰ U.S. Dep't of Justice and Fed. Trade Comm'n, *Statement of Antitrust Enforcement Policy in Healthcare* [Healthcare Statements] (1996) at 8, available at: www.ftc.gov/bc/healthcare/industryguide/policy/hlth3s.pdf.

⁵¹ 76 Fed. Reg. 67026-67032 (October 28, 2011). The Agencies' final statement is available at: <http://www.justice.gov/sites/default/files/atr/legacy/2011/10/20/276458.pdf>.

Furthermore, we are concerned that the narrowness of the self-referral exceptions with respect to physician compensation arrangements can make it exceedingly difficult to structure incentive payments tied to quality improvement criteria. In fact, the Government Accountability Office (GAO) has found that stakeholders' concerns about the legal framework for program integrity "may hinder implementation of financial incentive programs to improve quality and efficiency on a broad scale."⁵² The AMA believes that lawmakers and regulators should consider expanding exemptions to encourage innovative delivery and payment models. Without bright line guidance, program integrity provisions can deter the adoption of payment and delivery reforms, including bundled payments, medical homes, and other initiatives. More explicit and predictable guidance on when an arrangement will or will not prompt action under the fraud and abuse laws could have the dual effect of safeguarding against patient or program abuse while facilitating desired delivery system reform.

Competition plays an important role in enabling consumers to access the high quality care they deserve at a reasonable cost. The AMA urges federal and state regulators to closely scrutinize the proposed health insurer mergers and utilize enforcement tools to protect consumers and preserve competition. We strongly believe that further erosion of competition in health insurance markets is not in the best interests of patients and the physicians who serve them, and risks substantial harm to consumers in terms of access, quality, and cost.

The AMA applauds the Subcommittee's efforts to examine health insurance consolidation and enhance access, choice, and quality through improved competition. We appreciate the opportunity to provide our comments on this important topic, and we look forward to working with the Subcommittee and Congress on achieving high quality, cost-effective care for all Americans.

⁵² Government Accountability Office, Medicare: Implementation of Financial Incentive Programs under Federal Fraud and Abuse Laws. Report 12-355 (March 2012), *available at*: <http://www.gao.gov/products/GAO-12-355>.



Markets where an Aetna-Humana merger warrants antitrust scrutiny

Analysis of data from the 2015 update to "Competition in health insurance: A comprehensive study of U.S. markets"

Health Policy Group
American Medical Association

This analysis provides the *commercial* market share and concentration (HHI) effects of a proposed merger between Aetna and Humana. Data used in this analysis are from the 2015 Update to the American Medical Association's "Competition in health insurance" study (i.e., 2013 HealthLeaders-InterStudy data). Using the 2010 Department of Justice (DOJ)/Federal Trade Commission (FTC) Horizontal Merger Guidelines, it presents the state and metropolitan statistical area (MSA) level markets where the merger would raise competitive concerns based on how the Guidelines classify markets. Under the DOJ/FTC merger guidelines:

- MSAs with an HHI less than 1500 are *unconcentrated*; mergers are unlikely to raise competitive concerns.
- MSAs with an HHI between 1500 and 2500 are *moderately concentrated*; mergers that increase the HHI by more than 100 points potentially raise significant competitive concerns and often warrant scrutiny.
- MSAs with an HHI of more than 2500 are *highly concentrated*; mergers that increase the HHI by 100 to 200 points potentially raise significant competitive concerns and often warrant scrutiny, and those that increase it by more than 200 points will be presumed likely to enhance market power.

The following set of tables report those markets' pre- and post-merger HHIs and the change in HHIs resulting from the proposed merger. The results are presented for *commercial*, combined (HMO+PPO+POS) product markets, as well as for HMO, PPO and POS markets separately. For each product market, they are reported at the state-level and then by MSA.

Tables 1, 3, 5, 6, 8, 10 and 12 list those states and MSAs where such a merger would be presumed likely to enhance market power according to the guidelines above (i.e., combination of a highly concentrated market with a significant increase in the HHI). Those are the markets that would be expected to be most adversely affected by the merger.

Tables 2, 4, 7, 9, 11 and 13 list those states and MSAs where such a merger potentially raises significant competitive concerns and often warrants scrutiny (i.e., combination of moderately to highly concentrated market with a meaningful increase in the HHI).

Results for the combined (HMO+PPO+POS) product market

The results of the analysis in Table 1 conclude that an Aetna-Humana merger would be presumed likely to enhance market power in the *commercial*, combined (HMO+PPO+POS) markets in the state of Kentucky.

Also focusing on the *commercial*, combined (HMO+PPO+POS) markets, the results of the analysis in Table 2 conclude that an Aetna-Humana merger potentially raises significant competitive concerns and often warrants scrutiny in four additional states (TX, GA, UT, FL).

Although Table 1 and Table 2 show that the merger would cause important changes in the HHI (concentration), it should be noted that in the state of Kentucky, Aetna's pre-merger share was only 4.8 percent. Similarly, in the states listed in Table 2, Humana's pre-merger market shares were small—ranging from 3.7 percent in Florida to 4.6 percent in Texas. The significant increases in the HHI would be the result of Aetna's (or Humana's) high shares in those states.

Turning to the results by MSA, the results of the analysis in Table 3 conclude that an Aetna-Humana merger would be presumed likely to enhance market power in the *commercial*, combined (HMO+PPO+POS) markets in MSAs located in seven states (FL, GA, IL, KY, OH, TX, UT).

Also focusing on the *commercial*, combined (HMO+PPO+POS) markets, the results of the analysis in Table 4 conclude that an Aetna-Humana merger potentially raises significant competitive concerns and often warrants scrutiny in MSAs in 14 states (AZ, FL, GA, IL, IN, KY, LA, MS, OH, TN, TX, UT, WI, WV).

Results for separate HMO, PPO and POS product markets

Table 5 shows the six states (TN, KS, TX, OH, FL, GA) in which the merger will be presumed likely to enhance market power in the *HMO* market, and Table 8 shows the three states (UT, KY, TX) in which the merger will be presumed likely to enhance market power in the *PPO* market.

Table 9 shows that in six states (WI, CO, KS, IL, LA, MS), the merger potentially raises significant competitive concerns and often warrants scrutiny in the *PPO* market.

Turning to the results by MSA, Table 6 shows the MSAs, which are located across seven states (FL, GA, IL, MO, OH, TN, TX), where the merger is presumed likely to enhance market power in the *HMO* market. Table 10 shows that MSAs meeting those criteria in the *PPO* market are located in 14 states (CO, FL, IL, IN, KS, KY, LA, MO, MS, OH, TX, UT, WI, WV), and Table 12 shows one MSA (in GA) meeting those criteria in the *POS* market.

Table 7 shows the three MSAs (in FL, IL) where the merger potentially raises significant competitive concerns and often warrants scrutiny in the *HMO* market. Table 11 shows the MSAs classified in that way, which are located in 12 states (AZ, CO, FL, IL, IN, KS, LA, MO, MS, TN, TX, WI), for the *PPO* market, and Table 13 shows the one MSA (in GA) classified in that way for the *POS* market.

It is uncertain, however, whether separate product markets would be considered as constituting separate antitrust markets (i.e., not clear they are substitutes for each other).

Finally, it should be noted that although all MSA-level results show that the merger would cause important changes in the HHI (concentration), in many MSAs in the combined (HMO+PPO+POS) markets and in some MSAs in HMO and PPO markets, Humana's (or Aetna's) pre-merger shares were small, particularly when the change in the HHI was not very large. For example, that would generally be the case in many combined (HMO+PPO+POS) MSA-level markets across most states and in HMO and PPO markets in MSAs in several states (MO, FL, IL, CO, KS, MO, AZ, TX, IN, MS). The significant increases in the HHI are the result of Humana's (or Aetna's) high shares in those MSAs.

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Combined (HMO+PPO+POS) markets

Table 1. States where an Aetna-Humana merger will be presumed likely to enhance market power

State	Total HHI	Total HHI post-merger	Change in HHI
Kentucky	2992	3304	312

Table 2. States where an Aetna-Humana merger potentially raises significant competitive concerns and often warrants scrutiny

State	Total HHI	Total HHI post-merger	Change in HHI
Texas	2537	2699	162
Georgia	2127	2280	153
Utah	2232	2382	150
Florida	2285	2407	122

Table 3. MSAs where an Aetna-Humana merger will be presumed likely to enhance market power, by state

MSA name	Total HHI	Total HHI post-merger	Change in HHI
Florida			
Jacksonville, FL	2304	2592	289
Sarasota-Bradenton-Venice, FL	2463	2723	260
Tampa-St. Petersburg-Clearwater, FL	2372	2576	204
Georgia			
Macon, GA	2215	2819	604
Illinois			
Rockford, IL	3748	4023	276
Kentucky			
Louisville, KY-IN	2726	3081	355
Elizabethtown, KY	3586	3939	354
Lexington-Fayette, KY	2580	2865	285
Ohio			
Springfield, OH	1989	2593	604
Cincinnati-Middletown, OH-KY-IN	2591	2841	250
Texas			
El Paso, TX	2519	2871	352
San Antonio, TX	2455	2759	304
Corpus Christi, TX	2854	3062	207
Utah			
St. George, UT	2235	2522	287
Provo-Orem, UT	2719	2939	220

Markets where an Aetna-Humana merger warrants antitrust scrutiny | Analysis of data from the 2015 update to *Competition in Health Insurance*

Table 4. MSAs where an Aetna-Humana merger potentially raises significant competitive concerns and often warrants scrutiny, by state

MSA name	Total HHI	Total HHI post-merger	Change in HHI
Arizona			
Yuma, AZ	3196	3325	129
Florida			
Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	2109	2305	196
Lakeland-Winter Haven, FL	2170	2362	192
Miami-Miami Beach-Kendall, FL	1925	2080	154
West Palm Beach-Boca Raton-Boynton Beach, FL	2237	2377	140
Georgia			
Rome, GA	1982	2385	402
Gainesville, GA	1889	2169	280
Atlanta-Sandy Springs-Marietta, GA	2032	2249	217
Athens-Clarke County, GA	2265	2394	129
Illinois			
Kankakee-Bradley, IL	3636	3817	181
Bloomington-Normal, IL	3398	3544	146
Lake County-Kenosha County, IL-WI	3177	3316	138
Pecoria, IL	2580	2688	108
Indiana			
Evansville, IN-KY	3419	3539	120
Kentucky			
Owensboro, KY	4993	5112	119
Bowling Green, KY	3986	4101	115
Louisiana			
Lake Charles, LA	3502	3654	152
Monroe, LA	3455	3583	128
New Orleans-Metairie-Kenner, LA	3677	3794	118
Mississippi			
Gulfport-Biloxi, MS	2738	2917	179
Ohio			
Dayton, OH	2786	2929	143
Tennessee			
Clarksville, TN-KY	2034	2328	294
Johnson City, TN	3549	3655	106
Texas			
Victoria, TX	2965	3160	196
Beaumont-Port Arthur, TX	2697	2878	181
Houston-Sugar Land-Baytown, TX	2389	2566	178
San Angelo, TX	3287	3462	176
Brownsville-Harlingen, TX	3528	3687	159
Fort Worth-Arlington, TX	2578	2733	155
Killeen-Temple-Fort Hood, TX	1998	2152	155
Waco, TX	2178	2316	138
Austin-Round Rock, TX	2775	2912	137
McAllen-Edinburg Mission, TX	3560	3692	132

Markets where an Aetna-Humana merger warrants antitrust scrutiny | Analysis of data from the 2015 update to *Competition in Health Insurance*

MSA name	Total HHI	Total HHI post-merger	Change in HHI
Lubbock, TX	3010	3137	127
Dallas-Plano-Irving, TX	2647	2762	115
Tyler, TX	3410	3511	100
Utah			
Salt Lake City, UT	2200	2350	151
Wisconsin			
Milwaukee-Waukesha-West Allis, WI	3548	3698	150
Sheboygan, WI	2443	2590	147
Racine, WI	3683	3825	142
Oshkosh-Neenah, WI	1899	2028	129
Appleton, WI	2158	2280	122
West Virginia			
Huntington-Ashland, WV-KY-OH	1971	2315	344

HMO markets

Table 5. States where an Aetna-Humana merger will be presumed likely to enhance market power

State	HMO HHI	HMO HHI post-merger	Change in HMO HHI
Tennessee	3293	4584	1291
Kansas	4252	5471	1219
Texas	1894	2581	686
Ohio	1836	2521	685
Florida	2087	2684	597
Georgia	2511	2908	397

Table 6. MSAs where an Aetna-Humana merger will be presumed likely to enhance market power, by state

MSA name	HMO HHI	HMO HHI post-merger	Change in HMO HHI
Florida			
Jacksonville, FL	2823	4374	1551
Sarasota-Bradenton-Venice, FL	3566	4927	1361
Lakeland-Winter Haven, FL	2067	3176	1109
Tampa-St. Petersburg-Clearwater, FL	2176	3239	1063
West Palm Beach-Boca Raton-Boynton Beach, FL	2721	3764	1043
Orlando-Kissimmee, FL	2115	3096	981
Ocala, FL	2580	3407	827
Port St. Lucie-Fort Pierce, FL	3103	3799	696
Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	2867	3478	611
Miami-Miami Beach-Kendall, FL	2596	2878	282

Markets where an Aetna-Humana merger warrants antitrust scrutiny | Analysis of data from the 2015 update to *Competition in Health Insurance*

MSA name	HMO HHI	HMO HHI post-merger	Change in HMO HHI
Georgia			
Macon, GA	3495	5135	1639
Gainesville, GA	2760	3468	708
Atlanta-Sandy Springs-Marietta, GA	2845	3298	452
Illinois			
Kankakee-Bradley, IL	3503	5021	1518
Rockford, IL	3633	4954	1321
Missouri			
Kansas City, MO-KS	4843	5089	246
Ohio			
Cincinnati-Middletown, OH-KY-IN	5757	6332	575
Springfield, OH	8289	8851	562
Dayton, OH	6321	6722	401
Tennessee			
Clarksville, TN-KY	5414	7916	2503
Texas			
Houston-Sugar Land-Baytown, TX	3899	5659	1760
Austin-Round Rock, TX	2785	3954	1168
San Antonio, TX	2325	3303	979

Table 7. MSAs where an Aetna-Humana merger potentially raises significant competitive concerns and often warrants scrutiny, by state

MSA name	HMO HHI	HMO HHI post-merger	Change in HMO HHI
Florida			
Gainesville, FL	3528	3699	171
Deltona-Daytona Beach-Ormond Beach, FL	5588	5725	137
Illinois			
Peoria, IL	4295	4468	173

PPO markets

Table 8. States where an Aetna-Humana merger will be presumed likely to enhance market power

State	PPO HHI	Total PPO HHI post-merger	Change in PPO HHI
Utah	3572	4088	516
Kentucky	3661	4154	493
Texas	4529	4745	215

Table 9. States where an Aetna-Humana merger potentially raises significant competitive concerns and often warrants scrutiny

State	PPO HHI	Total PPO HHI post-merger	Change in PPO HHI
Wisconsin	1809	7252	443
Colorado	2810	2976	166
Kansas	3645	3788	142
Illinois	5214	5350	136
Louisiana	6189	6298	110
Mississippi	4883	4991	108

Table 10. MSAs where an Aetna-Humana merger will be presumed likely to enhance market power, by state

MSA name	PPO HHI	PPO HHI post-merger	Change in PPO HHI
Colorado			
Colorado Springs, CO	2720	3022	302
Grand Junction, CO	2518	2795	277
Florida			
Miami-Miami Beach-Kendall, FL	3305	3618	313
Tampa-St. Petersburg-Clearwater, FL	2865	3122	256
Lakeland-Winter Haven, FL	3346	3572	227
Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	3364	3580	215
Illinois			
Rockford, IL	5382	5648	266
Indiana			
Evansville, IN-KY	4634	4896	261
Kansas			
Wichita, KS	4402	4668	266
Kentucky			
Louisville, KY-IN	3633	4339	707
Elizabethtown, KY	4086	4582	496
Lexington-Fayette, KY	2931	3361	431

Markets where an Aetna-Humana merger warrants antitrust scrutiny | Analysis of data from the 2015 update to *Competition in Health Insurance*

MSA name	PPO HHI	PPO HHI post-merger	Change in PPO HHI
Louisiana			
New Orleans-Metairie-Kenner, LA	4806	5022	216
Lake Charles, LA	5560	5775	215
Missouri			
Columbia, MO	5466	5857	391
Jefferson City, MO	3148	3501	352
Springfield, MO	2990	3311	321
Mississippi			
Gulfport-Biloxi, MS	4118	4440	323
Ohio			
Cincinnati-Middletown, OH-KY-IN	3910	4220	310
Texas			
El Paso, TX	4236	4625	389
San Antonio, TX	4166	4536	370
Houston-Sugar Land-Baytown, TX	4283	4531	249
Corpus Christi, TX	4768	5013	245
Fort Worth-Arlington, TX	4309	4545	236
Austin-Round Rock, TX	4265	4499	234
Victoria, TX	4738	4959	221
Killeen-Temple-Fort Hood, TX	3164	3369	205
Utah			
Provo-Orem, UT	2511	4088	1577
St. George, UT	3246	3954	708
Salt Lake City, UT	3450	4067	618
Ogden-Clearfield, UT	2945	3432	487
Wisconsin			
Sheboygan, WI	2712	3608	897
Milwaukee-Waukesha-West Allis, WI	2338	3216	878
Racine, WI	2217	3094	877
Oshkosh-Neenah, WI	2249	2665	416
West Virginia			
Huntington-Ashland, WV-KY-OH	2296	2785	489

Table 11. MSAs where an Aetna-Humana merger potentially raises significant competitive concerns and often warrants scrutiny, by state

MSA name	PPO HHI	PPO HHI post-merger	Change in PPO HHI
Arizona			
Yuma, AZ	5092	5222	130
Colorado			
Greeley, CO	2834	3005	172
Boulder, CO	2867	3020	154
Pueblo, CO	3531	3669	138
Fort Collins-Loveland, CO	4030	4135	105

Markets where an Aetna-Humana merger warrants antitrust scrutiny | Analysis of data from the 2015 update to *Competition in Health Insurance*

MSA name	PPO HHI	PPO HHI post-merger	Change in PPO HHI
Florida			
Jacksonville, FL	4035	4215	179
Cape Coral-Fort Myers, FL	3408	3580	172
Palm Bay-Melbourne-Titusville, FL	2452	2621	170
Punta Gorda, FL	3045	3214	169
Fort Walton Beach-Crestview-Destin, FL	4638	4791	153
Illinois			
Bloomington-Normal, IL	4839	4999	161
Chicago-Naperville-Joliet, IL	5769	5921	152
Kankakee-Bradley, IL	6281	6400	120
Peoria, IL	3270	3372	102
Indiana			
Gary, IN	4721	4866	145
Bloomington, IN	5241	5378	137
Kansas			
Lawrence, KS	4606	4742	137
Louisiana			
Baton Rouge, LA	6064	6227	163
Houma-Bayou Cane-Thibodaux, LA	6498	6611	114
Monroe, LA	6662	6764	102
Lafayette, LA	6020	6122	102
Missouri			
Joplin, MO	2476	2674	198
Mississippi			
Jackson, MS	4919	5093	175
Tennessee			
Clarksville, TN-KY	3015	3186	171
Texas			
San Angelo, TX	5529	5728	200
Lubbock, TX	5596	5786	190
Beaumont-Port Arthur, TX	4614	4801	187
Waco, TX	4165	4350	186
Dallas-Plano-Irving, TX	4393	4575	182
Brownsville-Harlingen, TX	5418	5570	153
McAllen-Edinburg-Mission, TX	5737	5872	135
Tyler, TX	6108	6237	129
Sherman-Denison, TX	5195	5308	114
College Station-Bryan, TX	6097	6204	107
Arlene, TX	6437	6543	105
Wisconsin			
Appleton, WI	1961	2460	498
Green Bay, WI	1809	2203	394
Janesville, WI	1776	2056	280
Eau Claire, WI	2206	2384	178
Madison, WI	1711	1831	120

Markets where an Aetna-Humana merger warrants antitrust scrutiny | Analysis of data from the 2015 update to *Competition in Health Insurance*

POS markets

Table 12. MSAs where an Aetna-Humana merger will be presumed likely to enhance market power

MSA name	POS HHI	POS HHI post-merger	Change in POS HHI
Georgia			
Macon, GA	2815	2878	703

Table 13. MSAs where an Aetna-Humana merger potentially raises significant competitive concerns and often warrants scrutiny, by state

MSA name	POS HHI	POS HHI post-merger	Change in POS HHI
Georgia			
Gainesville, GA	2664	2783	118



Markets where an Anthem-Cigna merger warrants antitrust scrutiny

Analysis of data from the 2015 update to "Competition in Health Insurance: A comprehensive study of U.S. markets"

Health Policy Group
American Medical Association

This analysis provides the *commercial* market share and concentration (HHI) effects of a proposed merger between Anthem (WellPoint) and Cigna. Data used in this analysis are from the 2015 update to the American Medical Association's "Competition in health insurance" study (i.e., 2013 HealthLeaders-InterStudy data). Using the 2010 Department of Justice (DOJ)/Federal Trade Commission (FTC) Horizontal Merger Guidelines, it presents the state and metropolitan statistical area (MSA) level markets where the merger would raise competitive concerns based on how the Guidelines classify markets. Under the DOJ/FTC merger guidelines:

- MSAs with HHI less than 1500 are *unconcentrated*; mergers are unlikely to raise competitive concerns.
- MSAs with HHI between 1500 and 2500 are *moderately concentrated*; mergers that increase the HHI by more than 100 points potentially raise significant competitive concerns and often warrant scrutiny.
- MSAs with an HHI of more than 2500 are *highly concentrated*; mergers that increase the HHI by 100 to 200 points potentially raise significant competitive concerns and often warrant scrutiny, and those that increase it by more than 200 points will be presumed likely to enhance market power.

The following set of tables report those markets' pre- and post-merger HHIs and the change in HHIs resulting from the proposed merger. The results are presented for *commercial*, combined (HMO+PPO+POS) product markets, as well as for PPO and POS markets separately.¹ For each product market, they are reported at the state-level and then by MSA.

Tables 1, 3, 5, 7, 9 and 10 list those states and MSAs where such a merger would be presumed likely to enhance market power according to the guidelines above (i.e., combination of a highly concentrated market with a significant increase in the HHI). Those are the markets that would be expected to be most adversely affected by the merger.

Tables 2, 4, 6, 8 and 11 list those states and MSAs where such a merger potentially raises significant competitive concerns and often warrants scrutiny (i.e., combination of moderately to highly concentrated market with a meaningful increase in the HHI).

Results for the combined (HMO+PPO+POS) product market

The results of the analysis in Table 1 conclude that an Anthem-Cigna merger would be presumed likely to enhance market power in the *commercial*, combined (HMO+PPO+POS) markets in 10 of the 14 states (NH, IN, CT, ME, VA, GA, CO, MO, NV, KY) in which Anthem is licensed to provide commercial coverage.

¹ The analysis did not suggest any increased anticompetitive effects in the HMO product markets.

Also focusing on the *commercial, combined* (HMO+PPO+POS) markets, the results of the analysis in Table 2 conclude that an Anthem-Cigna merger potentially raises significant competitive concerns and often warrants scrutiny in the other four states where Anthem operates (OH, CA, NY, WI).

Although Table 1 and Table 2 show that the merger would cause important changes in the HHI (concentration), it should be noted that in the states of Kentucky and Wisconsin, Cigna's pre-merger market shares were only 4 percent and 3 percent respectively. The significant increases in the HHI would be the result of Anthem's high shares in those states.

Turning to the results by MSA, the results of the analysis in Table 3 conclude that an Anthem-Cigna merger would be presumed likely to enhance market power in the *commercial, combined* (HMO+PPO+POS) markets in MSAs located in 13 of the 14 states (CA, CO, CT, GA, IN, KY, ME, MO, NH, NY, OH, VA) in which Anthem is licensed to provide commercial coverage.

Also focusing on the *commercial, combined* (HMO+PPO+POS) markets, the results of the analysis in Table 4 conclude that an Anthem-Cigna merger potentially raises significant competitive concerns and often warrants scrutiny in MSAs located in CA, CT, KY, MO, NH, NY, OH, VA and WI.

Results for separate PPO and POS product markets

Table 5 shows the three states (IN, CO, GA) in which the merger will be presumed likely to enhance market power in the *PPO* market, and Table 9 shows that in all 14 "Anthem states" (CA, CO, CT, GA, IN, KY, ME, MO, NY, OH, VA, WI), the merger will be presumed likely to enhance market power in the *POS* market.

Table 6 shows that in one additional state (NV), the merger potentially raises significant competitive concerns and often warrants scrutiny in the *PPO* market.

Turning to the results by MSA, Table 7 shows the MSAs, which are located across nine states (CA, CO, IN, GA, ME, MO, NH, OH, VA), where the merger is presumed likely to enhance market power in the *PPO* market; and Table 10 shows that MSAs meeting those criteria in the *POS* market are located in all 14 "Anthem states" (CA, CO, CT, GA, IN, KY, ME, MO, NY, OH, VA, WI).

Table 8 shows one additional MSA (in NV) where the merger potentially raises significant competitive concerns and often warrants scrutiny in the *PPO* market, and Table 11 shows MSAs classified in that way—located in OH and WI—for the *POS* market.

It is uncertain, however, whether separate product markets would be considered as constituting separate antitrust markets (i.e., not clear they are substitutes for each other).

Finally, it should be noted that although all MSA-level results show that the merger would cause important changes in the HHI (concentration), in some MSAs Cigna's pre-merger shares were small, particularly when the change in the HHI was not very large. For example, that would generally be the case in combined (HMO+PPO+POS) and *PPO* markets in California and Ohio MSAs. The significant increase in the HHI in these two states would be the result of Anthem's high shares in those MSAs.

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Combined (HMO+PPO+POS) markets

Table 1. States where an Anthem-Cigna merger will be presumed likely to enhance market power

State	Total HHI	Total HHI post-merger	Change in HHI
New Hampshire	2769	4452	1682
Indiana	3385	4999	1614
Connecticut	2544	3855	1311
Maine	2921	4089	1169
Virginia	2545	3439	894
Georgia	2127	2976	848
Colorado	1893	2734	841
Missouri	2074	2576	502
Nevada	2459	2906	447
Kentucky	2992	3323	331

Table 2. States where an Anthem-Cigna merger potentially raises significant competitive concerns and often warrants scrutiny

State	Total HHI	Total HHI post-merger	Change in HHI
Ohio	2043	2354	311
California	2108	2399	291
New York	1712	1921	210
Wisconsin	1482	1592	109

Table 3. MSAs where an Anthem-Cigna merger will be presumed likely to enhance market power, by state

MSA name	Total HHI	Total HHI post-merger	Change in HHI
California			
Santa Cruz-Watsonville, CA	2934	3530	596
Santa Ana-Anaheim-Irvine, CA	1986	2514	528
Santa Barbara-Santa Maria, CA	3371	3849	478
Salinas, CA	4446	4888	442
Orland-Thousand Oaks-Ventura, CA	2471	2838	367
Los Angeles-Long Beach-Glendale, CA	2256	2575	319
Bakersfield, CA	2664	2969	305
El Centro, CA	3125	3416	291
Modesto, CA	2453	2668	215
Colorado			
Grand Junction, CO	2040	3371	1331
Fort Collins-Loveland, CO	2457	3711	1253
Greeley, CO	2055	3180	1125

Markets where an Anthem-Cigna merger warrants antitrust scrutiny | Analysis of data from the 2015 update to *Competitive in Health Insurance*

MSA name	Total HHI	Total HHI post-merger	Change in HHI
Pueblo, CO	1990	2939	949
Colorado Springs, CO	1725	2671	947
Boulder, CO	1999	2899	900
Denver-Aurora, CO	2000	2631	631
Connecticut			
Hartford-West Hartford-East Hartford, CT	2426	3783	1357
New Haven-Milford, CT	3139	4440	1300
Waterbury, CT	3108	4403	1295
Bridgeport-Stamford-Norwalk, CT	2442	3723	1282
Danbury, CT	2355	3591	1236
Norwich-New London-Westerley, CT-RI	3121	3921	800
Georgia			
Dalton, GA	3340	5924	2584
Columbus, GA-AL	2780	3998	1218
Valdosta, GA	3113	4291	1178
Savannah, GA	2389	3549	1160
Hinesville-Fort Stewart, GA	3543	4695	1152
Rome, GA	1982	3090	1107
Albany, GA	3142	4203	1061
Brunswick, GA	2935	3880	944
Warner Robins, GA	3701	4587	886
Atlanta-Sandy Springs-Marietta, GA	2032	2758	726
Athens-Clarke County, GA	2265	2946	681
Gainesville, GA	1889	2545	656
Macon, GA	2215	2720	505
Augusta-Richmond County, GA-SC	1996	2500	505
Indiana			
Indianapolis, IN	3299	5716	2417
Lafayette, IN	2780	4762	1982
Terre Haute, IN	5436	7047	1611
Kokomo, IN	3764	5191	1427
Anderson, IN	4803	6073	1270
Gary, IN	3059	4274	1215
Evansville, IN-KY	3419	4621	1202
Fort Wayne, IN	3595	4762	1167
Michigan City-La Porte, IN	4064	5135	1071
Elkhart-Goshen, IN	4328	5161	833
Muncie, IN	3771	4299	528
South Bend-Mishawaka, IN-MI	2813	3295	482
Bloomington, IN	3748	4189	440
Kentucky			
Bowling Green, KY	3986	4895	909
Owensboro, KY	4993	5589	596
Louisville, KY-IN	2726	3166	441

Markets where an Anthem-Cigna merger warrants antitrust scrutiny | Analysis of data from the 2015 update to *Competition in Health Insurance*

MSA name	Total HHI	Total HHI post-merger	Change in HHI
Maine			
Bangor, ME	2884	4427	1543
Lewiston-Auburn, ME	3234	4597	1362
Portland-South Portland, ME	2872	3870	998
Missouri			
Joplin, MO	2117	2676	559
St. Louis, MO-IL	2571	3100	529
Jefferson City, MO	2779	3165	386
Springfield, MO	2281	2553	272
Kansas City, MO-KS	2307	2548	241
Columbia, MO	3405	3612	207
New Hampshire			
Rochester-Dover, NH	2808	4354	1546
Manchester, NH	2683	4215	1531
Nashua, NH-MA	2384	3640	1256
Portsmouth, NH-ME	2733	3940	1207
Nevada			
Carson City, NV	2092	2503	411
Las Vegas-Paradise, NV	3138	3491	352
New York			
Suffolk County-Nassau County, NY	2928	3162	233
Ohio			
Weirton-Steubenville, WV-OH	2458	2966	508
Cincinnati-Middletown, OH-KY-IN	2591	3027	435
Columbus, OH	2363	2716	353
Lima, OH	2320	2661	342
Dayton, OH	2786	3112	326
Sandusky, OH	2677	3002	324
Tennessee			
Kingsport-Bristol, TN-VA	2345	3085	739
Chattanooga, TN-GA	2623	3157	533
Virginia			
Richmond, VA	3514	5241	1727
Winchester, VA-WV	3663	4851	1188
Lyndburg, VA	4484	5436	952
Roanoke, VA	4358	5069	710
Virginia Beach-Norfolk-Newport News, VA-NC	3333	3977	644
Blacksburg-Christiansburg-Radford, VA	4902	5528	626
Danville, VA	7177	7724	548
Harrisonburg, VA	5473	5987	514
Charlottesville, VA	3212	3545	333

Table 4. MSAs where an Anthem-Cigna merger potentially raises significant competitive concerns and often warrants scrutiny, by state

MSA name	Total HHI	Total HHI post-merger	Change in HHI
California			
San Jose-Sunnyvale-Santa Clara, CA	2112	2453	341
San Diego-Carlsbad-San Marcos, CA	1622	1890	267
San Francisco-San Mateo-Redwood City, CA	2063	2305	242
Riverside-San Bernardino-Ontario, CA	2162	2375	213
Oakland-Fremont-Hayward, CA	2859	3031	172
Sacramento-Arden-Arcade-Roseville, CA	2466	2578	112
District of Columbia			
Washington-Arlington-Alexandria, DC-VA-MD-WV	1760	2086	326
Massachusetts			
Haverhill-Newburyport-Amesbury Town, MA-NH	1760	2107	347
Lawrence-Methuen-Salem, MA-NH	2023	2205	182
Springfield, MA-CT	1966	2106	140
Missouri			
St. Joseph, MO-KS	3221	3359	138
Nevada			
Reno-Sparks, NV	1913	2416	503
New York			
New York-White Plains-Wayne, NY-NJ	1987	2319	332
Poughkeepsie-Newburgh-Middletown, NY	1781	2009	228
Ohio			
Canton-Massillon, OH	1904	2143	239
Youngstown-Warren-Boardman, OH-PA	1978	2214	236
Akron, OH	2197	2425	227
Toledo, OH	2247	2449	201
Cleveland-Elyria-Mentor, OH	2658	2843	185
Mansfield, OH	2911	3034	123
Tennessee			
Clarksville, TN-KY	2034	2413	379
Wisconsin			
Racine, WI	3683	3848	165
Milwaukee-Waukesha-West Allis, WI	3548	3683	135
Janesville, WI	1487	1605	118
West Virginia			
Huntington-Ashland, WV-KY-OH	1971	2257	286
Wheeling, WV-OH	1899	2153	254

PPO markets

Table 5. States where an Anthem-Cigna merger will be presumed likely to enhance market power

State	PPO HHI	PPO HHI post-merger	Change in PPO HHI
Indiana	4771	6509	1737
Colorado	2810	3820	1010
Georgia	3214	3592	379

Table 6. States where an Anthem-Cigna merger potentially raises significant competitive concerns and often warrants scrutiny

State	PPO HHI	PPO HHI post-merger	Change in PPO HHI
Nevada	1901	2450	549

Table 7. MSAs where an Anthem-Cigna merger will be presumed likely to enhance market power, by state

MSA name	PPO HHI	PPO HHI post-merger	Change in PPO HHI
California			
Santa Cruz-Watsonville, CA	4403	4975	572
El Centro, CA	3377	3724	347
Colorado			
Greeley, CO	2834	4324	1491
Pueblo, CO	3531	4767	1235
Fort Collins-Loveland, CO	4030	5106	1076
Denver-Aurora, CO	2770	3657	887
Colorado Springs, CO	2720	3592	872
Grand Junction, CO	2518	3342	824
Boulder, CO	2867	3608	742
District of Columbia			
Washington-Arlington-Alexandria, DC-VA-MD-WV	2535	2788	253
Georgia			
Dalton, GA	3110	5668	2558
Valdosta, GA	2184	3892	1707
Hinesville-Fort Stewart, GA	2277	3127	850
Brunswick, GA	2423	3269	846
Albany, GA	2474	3231	757
Rome, GA	3646	4239	593
Warner Robins, GA	2601	3131	530
Savannah, GA	2221	2742	526
Athens-Clarke County, GA	2890	3398	508

Metros where an Anthem-Cigna merger warrants antitrust scrutiny | Analysis of data from the 2015 update to *Competition in Health Insurance*

MSA name	PPO HHI	PPO HHI post-merger	Change in PPO HHI
Georgia			
Macon, GA	2741	3153	411
Columbus, GA-AL	2222	2592	370
Atlanta-Sandy Springs-Marietta, GA	4059	4300	241
Augusta-Richmond County, GA-SC	2716	2921	205
Indiana			
Indianapolis, IN	4188	7423	3234
Gary, IN	4721	5571	850
Elkhart-Goshen, IN	6013	6660	647
Terre Haute, IN	6949	7563	614
Evansville, IN-KY	4634	5127	493
Maine			
Bangor, ME	2508	3943	1435
Missouri			
Jefferson City, MO	3148	3539	391
Joplin, MO	2476	2781	306
New Hampshire			
Rochester-Dover, NH	3467	4052	585
Ohio			
Lima, OH	3330	3583	253
Columbus, OH	2803	3053	250

Table 8. MSAs where an Anthem-Cigna merger potentially raises significant competitive concerns and often warrants scrutiny, by state

MSA name	PPO HHI	PPO HHI post-merger	Change in PPO HHI
Nevada			
Las Vegas-Paradise, NV	1864	2331	467

POS markets

Table 9. States where an Anthem-Cigna merger will be presumed likely to enhance market power

State	POS HHI	Total POS HHI post-merger	Change in POS HHI
Maine	4200	7684	3483
New Hampshire	3595	6477	2882
Connecticut	2884	4858	1974
Indiana	2855	4337	1482
Virginia	2352	3715	1363
Georgia	2988	4244	1256
California	3037	4228	1191
Nevada	3857	4842	985
Kentucky	3363	4235	872
Colorado	4196	4875	680
Missouri	4153	4768	615
Ohio	4197	4712	515
New York	3994	4401	407
Wisconsin	5123	5332	208

Table 10. MSAs where an Anthem-Cigna merger will be presumed likely to enhance market power, by state

MSA name	POS HHI	Total POS HHI post-merger	Change in POS HHI
California			
Santa Barbara-Santa Maria, CA	3025	5236	2212
Salinas, CA	3599	5663	2064
Visalia-Porterville, CA	3478	5386	1907
Madera, CA	3655	5560	1904
Modesto, CA	3184	5065	1881
San Luis Obispo-Paso Robles, CA	3850	5651	1801
Napa, CA	3453	5241	1788
Merced, CA	3308	5077	1769
Fresno, CA	3410	5068	1658
Redding, CA	4094	5559	1555
Oxnard-Thousand Oaks-Ventura, CA	3034	4587	1553
Santa Cruz-Watsonville, CA	3062	4614	1552
Bakersfield, CA	3269	4753	1485
Santa Ana-Anaheim-Irvine, CA	3130	4527	1397
Stockton, CA	3360	4716	1356
Los Angeles-Long Beach-Glendale, CA	2669	3952	1283
Yuba City-Marysville, CA	4159	5353	1194
Sacramento-Arden-Arcade-Roseville, CA	3613	4705	1092
Chico, CA	4020	5098	1078
Vallejo-Fairfield, CA	3813	4755	942

Markets where an Anthem-Cigna merger warrants antitrust scrutiny | Analysis of data from the 2015 update to *Competition in Health Insurance*

MSA name	POS HHI	Total POS HHI post-merger	Change in POS HHI
Santa Rosa-Petaluma, CA	3892	4831	939
San Diego-Carlsbad-San Marcos, CA	3531	4455	924
Oakland-Fremont-Hayward, CA	3878	4715	837
San Francisco-San Mateo-Redwood City, CA	3970	4747	777
Riverside-San Bernardino-Ontario, CA	2391	3165	774
San Jose-Sunnyvale-Santa Clara, CA	3854	4535	681
Colorado			
Grand Junction, CO	3875	4724	850
Colorado Springs, CO	3921	4741	819
Fort Collins-Loveland, CO	4111	4920	809
Pueblo, CO	4000	4807	806
Boulder, CO	4176	4888	711
Greeley, CO	4140	4842	701
Denver-Aurora, CO	4406	4938	531
Connecticut			
Waterbury, CT	2953	5442	2489
New Haven-Milford, CT	2967	5454	2488
Hartford-West Hartford-East Hartford, CT	2866	4755	1888
Bridgeport-Stamford-Norwalk, CT	3201	4982	1780
Danbury, CT	3153	4831	1678
Norwich-New London-Westerley, CT-RI	3244	4326	1082
District of Columbia			
Washington-Arlington-Alexandria, DC-VA-MD-WV	2944	3327	383
Georgia			
Dalton, GA	5271	8764	3493
Columbus, GA-AL	3546	5296	1751
Rome, GA	2571	4093	1522
Savannah, GA	2916	4357	1441
Athens-Clarke County, GA	3554	4914	1360
Hinesville-Fort Stewart, GA	4193	5536	1343
Atlanta-Sandy Springs-Marietta, GA	2899	4086	1186
Warner Robins, GA	4331	5506	1175
Albany, GA	3900	5052	1152
Gainesville, GA	2664	3694	1030
Brunswick, GA	3815	4845	1030
Valdosta, GA	3777	4571	793
Augusta-Richmond County, GA-SC	3256	4010	755
Macon, GA	2615	3338	723
Indiana			
Kokomo, IN	3296	6036	2740
Terre Haute, IN	3560	6142	2582
Anderson, IN	3328	5565	2237
Lafayette, IN	4053	6046	1993
Fort Wayne, IN	3261	5123	1862
Evansville, IN-KY	2984	4649	1665
Indianapolis, IN	3166	4821	1655
Michigan City-La Porte, IN	3377	4938	1561

Markets where an Anthem-Cigna merger warrants antitrust scrutiny | Analysis of data from the 2015 update to *Competition in Health Insurance*

MSA name	POS HHI	Total POS HHI post-merger	Change in POS HHI
Elkhart-Goshen, IN	3742	4971	1229
Gary, IN	3470	4640	1170
South Bend-Mishawaka, IN-MI	3669	4835	1166
Muncie, IN	2747	3453	706
Bloomington, IN	3121	3621	500
Kentucky			
Bowling Green, KY	2937	4836	1898
Owensboro, KY	3573	4802	1229
Elizabethtown, KY	3140	4187	1046
Lexington-Fayette, KY	3359	4175	816
Louisville, KY-IN	3983	4658	675
Massachusetts			
Haverhill-Newburyport-Amesbury Town, MA-NH	3220	4863	1643
Lawrence-Methuen-Salem, MA-NH	3256	4514	1258
Springfield, MA-CT	3046	4286	1240
Worcester, MA-CT	3339	4238	899
Lowell-Billerica-Chelmsford, MA-NH	3538	4337	799
Maine			
Lewiston-Auburn, ME	4479	8454	3975
Bangor, ME	4089	7950	3861
Portland-South Portland, ME	4135	7204	3069
Minnesota			
Duluth, MN-WI	4710	5067	357
Minneapolis-St. Paul-Bloomington, MN-WI	3845	4093	249
Missouri			
St. Joseph, MO-KS	3648	4959	1311
Joplin, MO	4289	5097	808
Springfield, MO	4465	5018	553
Columbia, MO	5086	5532	446
Kansas City, MO-KS	4183	4618	435
St. Louis, MO-IL	4540	4955	415
Jefferson City, MO	5704	5993	289
New Hampshire			
Rochester-Dover, NH	3562	6681	3119
Manchester, NH	3481	6066	2585
Portsmouth, NH-ME	3372	5939	2567
Nashua, NH-MA	3401	5799	2398
Nevada			
Reno-Sparks, NV	3862	4757	896
Las Vegas-Paradise, NV	4125	4965	839
New York			
Glens Falls, NY	2799	4210	1411
Albany-Schenectady-Troy, NY	3098	3985	887
Kingston, NY	4051	4792	742
Poughkeepsie-Newburgh-Middletown, NY	4147	4875	729
Suffolk County-Nassau County, NY	5418	5783	365
New York-White Plains-Wayne, NY-NJ	3792	4135	343

Markets where an Anthem-Cigna merger warrants antitrust scrutiny | Analysis of data from the 2015 update to *Competition in Health Insurance*

MSA name	POS HHI	Total POS HHI post-merger	Change in POS HHI
Ohio			
Weirton-Steubenville, WV-OH	2668	4266	1598
Sandusky, OH	3340	4729	1389
Lima, OH	3647	4976	1330
Canton-Massillon, OH	3194	3996	802
Youngstown-Warren-Boardman, OH-PA	3811	4606	795
Cleveland-Elyria-Mentor, OH	3488	4199	711
Akron, OH	2670	3364	694
Toledo, OH	2875	3463	588
Cincinnati-Middletown, OH-KY-IN	4105	4628	524
Mansfield, OH	4869	5344	474
Dayton, OH	4828	5124	296
Columbus, OH	6039	6327	288
Tennessee			
Chattanooga, TN-GA	3889	5367	1478
Clarksville, TN-KY	2652	3811	1159
Kingsport-Bristol, TN-VA	4993	6033	1041
Virginia			
Winchester, VA-WV	3381	6088	2707
Richmond, VA	3177	5294	2117
Blacksburg-Christiansburg-Radford, VA	3600	5559	1959
Roanoke, VA	3364	5242	1878
Lynchburg, VA	2541	4301	1760
Danville, VA	4377	6011	1634
Harrisonburg, VA	3015	4342	1327
Virginia Beach-Norfolk-Newport News, VA-NC	2553	3828	1275
Charlottesville, VA	2269	2853	583
Wisconsin			
Madison, WI	2318	3596	1278
Janesville, WI	2246	3048	802
La Crosse, WI-MN	3323	3971	648
West Virginia			
Wheeling, WV-OH	2741	3551	810
Huntington-Ashland, WV-KY-OH	3513	4321	808

Table 11. MSAs where an Anthem-Cigna merger potentially raises significant competitive concerns and often warrants scrutiny, by state

MSA name	POS HHI	POS HHI post-merger	Change in POS HHI
Ohio			
Springfield, OH	4877	5027	150
Wisconsin			
Racine, WI	6766	6895	129
Milwaukee-Waukesha-West Allis, WI	6813	6923	110

Markets where an Anthem-Cigna merger warrants antitrust scrutiny | Analysis of data from the 2015 update to *Competition in Health Insurance*

Mr. MARINO. Thank you, sir.
Professor King?

**TESTIMONY OF JAIME S. KING, PROFESSOR OF LAW,
UNIVERSITY OF CALIFORNIA, HASTINGS COLLEGE OF LAW**

Ms. KING. Chairman Goodlatte, Subcommittee Chairman Marino, Committee Ranking Member Conyers, and Subcommittee Ranking Member Johnson, and Members of the Subcommittee, I very much appreciate the opportunity to testify on the potential impact of the proposed mergers on consumers, competition, and the American health care system.

After decades of increased consolidation in provider and insurer markets, resulting in ever-escalating health insurance premiums and health care expenditures, the American public has begun to demand more accountability for health care costs from their providers, insurers, and policymakers.

Reform efforts, big and small, have started to shift the playing field for providers and insurers. And in many ways, the proposed mergers appear to be more about staking out territory and acquiring leverage in the new health care economy than anything else.

How the dust settles in our health care system will have significant implications for the lives of all Americans, the efficient functioning of our economy, and the well-being of our Nation. We must be cautious and deliberate in our actions.

Policymakers and government agencies charged with overseeing the health care system must be both exacting in their analysis of the proposed mergers on existing product and geographic markets. But they also have to have the vision to see the broader picture of how these mergers will affect consumers across the Nation and the health care system as a whole, in the years to come.

The proposed mergers present several risks to tens of millions of affected consumers in an array of private insurance markets throughout the country, including individuals, small group, large group, self-insured, and Medicare Advantage markets. A recent study by the Government Accountability Office found that market share was highly concentrated into the top three insurers in individual, small group, and large group markets in 37 States.

In reviewing the proposed merger, the Department of Justice will consider whether the mergers will likely lead to increased premiums, reductions in quality and innovation, or other harms to competition and consumers.

In terms of premiums, as we have heard before, the research consistently found that increased premiums occurred in the wake of an insurance merger. While there is some evidence that consolidation among insurers can result in reductions and lower provider reimbursements, no evidence has ever found that those savings were returned to consumers. So basically, physicians will make less money and consumers will continue to overpay for health care.

This is a trend that the American consumer can no longer sustain. Private insurance premiums are at their highest levels in history, almost approaching \$17,000 for the average family.

Some have argued that the medical loss ratio will prevent consolidated mergers from increasing premiums, but the MLR depends on competition to function. And in markets without competition,

the MLR can be gameable. Because it limits administrative costs to the percentage of total premiums, in the absence of competition, insurers have incentive to go ahead and allow provider reimbursement rates to grow and increase overall premiums, thereby increasing their overall share of the pie.

Moreover, the MLR does not apply to enrollees in self-insured plans, which make up over half of the private insurance market, leaving them still at risk of premium increases.

In terms of the potential negative impacts to quality and competition, I want to say a little bit about Medicare Advantage and the health insurance marketplaces. America is not getting any younger and a strong presence in the Medicare Advantage markets will be an important point of leverage for health insurers in the future.

Unfortunately, these markets are already highly concentrated throughout the country, with 97 percent of counties exceeding merger guideline standards for high concentration.

Medicare Advantage was designed to operate in a competitive market, and incentives to promote quality and innovation in those plans will not function in the absence of competition from other Medicare Advantage plans. There is evidence that consumers differentiate between these products and traditional Medicare, and they have been treated as separate markets by the FTC in the past.

Similarly, this effect on quality and innovation can also occur in markets subject to the medical loss ratio. Not only would mergers eliminate key potential competitors in these markets, but they also may serve to chill the incentives of these established insurers to expand their territory into the space and increase competition. The same can be said for the State health insurance markets.

Insurers may try to overcome these potential anticompetitive effects by claiming that their mergers will produce procompetitive effects, efficiencies. Things like consumer engagement and helping with the transition to value-based goals and plans will be beneficial, but they also have to be merger-specific. They have to show that they will occur in the absence of a merger. They also have to show they will be cognizable and cannot be achieved through anti-competitive means.

So in conclusion, the insurance companies today have argued that all insurance, like politics, is local. But just as we know that the broader political climate and decisions made in Washington have great effects on all of us back at home, the same is true of health insurance. Thank you.

[The prepared statement of Ms. King follows:]

**Prepared Statement of Jamie S. King, Professor of Law,
University of California, Hastings College of Law**

Chairman Goodlatte, Subcommittee Chairman Marino, Committee Ranking Member Conyers, Subcommittee Ranking Member Johnson, and Members of the Subcommittee, I very much appreciate the opportunity to testify on the potential impact of the proposed mergers of Aetna and Humana and Anthem and Cigna on consumers and competition in the American health care system. I am a professor of law at the University of California Hastings College of the Law and the Associate Dean and Co-Director of the UCSF/UC Hastings Consortium on Law, Science and Health Policy. I have written and taught in the field of health law and policy for the last seven years. I am also the Co-Founder and Executive Editor of The Source on Healthcare Price and Competition, a free and independent academic website that posts news, academic articles, legislative developments, litigation documents, original analysis, and guest commentary on health care price and competition. My co-founder, Anne Marie Helm, and I developed the Source to bridge gaps among health policy, health services research, and legal experts working on these issues, as well as to serve as a resource for others seeking to understand and promote cost control and competition in health care.

Introduction

This is a dynamic time in the U.S. health care system. After decades of increased consolidation in provider and insurer markets resulting in ever-escalating health insurance premiums and health care expenditures, the American public has begun to demand more accountability for health care costs from their providers, insurers, and policymakers. Reform efforts, big and small, have started to shift the playing field for providers and insurers and new alliances are being formed.

In many ways, the proposed mergers between Aetna and Humana and Anthem and Cigna (“Proposed Mergers”) appear to be about staking out territory and acquiring leverage in the new health care economy. In the next three to five years, we will likely see a great increase in provider and insurer collaboration, but we will also likely see increased tension between the two groups over reimbursements and market profits.¹ Furthermore, large health care provider organizations and other new entities have begun to enter the health insurance market with innovative products, which threatens insurance companies’ market clout and profits. After years of being stagnant, the number of provider organizations launching or expanding plans is rising, which has many payers concerned.² For more established insurers, these shifts in the market make it an ideal time to secure and extend their market positions in order to entrench their status in the new American health care economy.

To be sure, this dynamic time is also a fragile time. How the dust settles in our health care system will have significant implications for the lives of all Americans, the efficient functioning of our economy, and the wellbeing of our nation. We must be cautious and deliberate

¹ Joseph Conn, *Closer Provider-Insurer Ties Bring New Challenges*, MODERN HEALTHCARE (Aug. 15, 2015) [hereinafter *Provider-Insurer Ties Bring New Challenges*] available at <http://www.modernhealthcare.com/article/20150815/MAGAZINE/308159969>.

² Joseph Swedish, “Prepared Statement,” United States Senate Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights, Sept. 22, 2015, at 11 [hereinafter *Swedish Statement*] available at <http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Swedish%20Testimony.pdf> (“Providers are also entering the health insurance marketplace in rapidly growing numbers. According to a PwC analysis from 2014, ‘some 50 percent of U.S. health systems have applied – or intend to apply – for an insurance license.’ Just a few examples of health systems that have entered the insurance market include: Ochsner Health System, Sentara Healthcare, Tenet/Vanguard, and Ascension Catholic Health.”)

in our actions. Policymakers and government agencies charged with overseeing the health care system must be both exacting in their analysis of the impact of the Proposed Mergers on existing product and geographic markets, and have the vision to see the broader picture of how these mergers could affect consumers and the health care system as a whole.

The Proposed Mergers present several risks to millions of affected consumers. Primarily, in the wake of an insurance merger, consumer premiums and insurer profits tend to increase.³ This is a trend that American consumers can no longer sustain. Private insurance premiums are at their highest levels in history (\$16,834 for the average family), plus out of pocket spending has risen to an average of \$800 per person.⁴ Consumers may also be harmed by reductions in competition that hinder incentives to improve quality and innovate. Furthermore, the pace of innovation and change in health insurance markets, with the shift to value-based reimbursement methods and the development of Accountable Care Organizations (“ACOs”) and Tiered Networks, suggest that this is an inopportune time to dramatically alter the markets in ways that may have a chilling effect on innovation.

My testimony today will focus on some of the broader potential impacts of the Proposed Mergers, and will go into more depth on some especially relevant examples. I also provide some guidance to the methods and tools the Department of Justice (“DOJ”) may use to analyze the Proposed Mergers, but again, analysis of these mergers will require extensive fact gathering across the wide array of affected product and geographic markets, as well as significant economic and legal analysis. My comments seek to highlight potentially relevant and important features of the mergers for consideration of this Subcommittee and further review by the DOJ.

Summary of Key Points

- High concentration in provider and insurance markets in the United States hinders the efficient functioning of the U.S. health care system and drives up costs for consumers, employers, and taxpayers.
- From a historical perspective, insurance mergers have resulted in premium increases for consumers.
- The Medical Loss Ratio does not guarantee that dominant insurers will not raise premiums and as such, it should not be a substitute for the pressures toward lower costs and higher quality present in a competitive market.
- Permitting four of the five largest health insurance companies to merge threatens to consolidate market power locally and nationally in ways that have repercussions well

³ Leemore Dafny et al., *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, 102 AM. ECON. REV. 1161 (2012) [hereinafter *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*].

⁴ Kaiser Family Foundation and Health Research & Educational Trust, “2014 Survey of Employer Health Benefits,” available at <http://kff.org/health-costs/report/2014-employer-health-benefits-survey>; Health Cost Institute, 2013 Health Care Cost and Utilization Report, available at <http://www.healthcostinstitute.org/2013-health-care-cost-and-utilization-report>.

beyond any one individual market and could frustrate the progress that has been made by the Affordable Care Act to promote competition and cost control.

- The product market for Medicare Advantage can be differentiated from the market for traditional Medicare, such that maintaining competition among Medicare Advantage plans to promote quality and innovation is important.
- The relative permanence of a decision to approve the Proposed Mergers as well as the sheer impact on competition throughout the U.S. health care markets of losing two of the five largest health insurers markets demands a great deal of caution and skepticism.
- The DOJ should scrutinize the potential impact of these mergers on product markets at the local, state, and national level, while keeping a close eye on the overarching impact of the consolidation for the entire health care system.

I. Competition and the U.S. Health Care Market

The United States has experienced more than a 400 percent increase in total health care expenditures since 1990.⁵ By 2013, health care expenditures exceeded \$2.9 trillion and represented 17.4 percent of our GDP. Yet, while we pay more per capita than any other nation for health care, the health of American citizens does not reflect this sacrifice. In large part, our health care costs so much because we overuse and overpay for health care goods and services. In the simplest of terms, we overuse care due to rampant inefficiencies in the system and payment incentives that reward higher volume care, rather than higher value care. We overpay for services due to severe imperfections in the health care market, including asymmetric information between physicians and patients, a lack of price transparency, high barriers to entry, an inelastic demand for health care, and highly concentrated health care markets that facilitate the abuse of market power.

Our current health care system depends on competition to control costs and promote quality. At present, we are making strides to curb overutilization by shifting payment incentives from reimbursement models that reward high volume care to those that reward high value care. But, our commitment to value based care will not bend the cost curve without a simultaneous and sustained effort to protect competition and prevent the systemic attainment and abuse of market power. Due to its market imperfections, protecting competition in health care requires careful oversight and regulation. Further, the dual roles of insurers as both buyers of health care goods and services and sellers of health plans add an additional layer of complexity to market analysis and oversight.

Unfortunately, over the last twenty years, not enough has been done to protect competition in American health care markets. In that time, both provider and payer markets have undergone unprecedented consolidation, which has led to price increases for consumers. Consolidation in the provider market sets an important backdrop for understanding the implications of the proposed insurance mergers, and so I will touch on it briefly.

A. Provider Consolidation

⁵ Centers for Disease Control and Prevention, "Gross Domestic Product, National Health Expenditures, Per Capita Amounts, Percent Distribution, and Average Annual Percent Change: United States, Selected Years 1960-2013," Table 102, available at <http://www.cdc.gov/nchs/data/has/2014/102.pdf>.

Concentration in the hospital market has become “pervasive.”⁶ From 2003 to 2009, between 40 and 60 hospitals merged each year, and from 2010 to 2013, this number nearly doubled to between 70 and 110.⁷ By 2013, nearly half of hospital markets in the United States were highly concentrated, another third were moderately concentrated, and the remaining one-sixth were not concentrated.⁸ No hospital markets were considered highly competitive. During this time, hospitals also began to integrate vertically with physician organizations, and by 2011 nearly 70 percent of physician practices were owned by a hospital.⁹

A wide body of literature indicates that increased hospital concentration leads to increased hospital prices and insurance premiums.¹⁰ In 2012, health economists Martin Gaynor and Robert Town conducted a systemic review of the literature that found mergers in concentrated markets resulted in price increases over 20 percent.¹¹ Hospital mergers that create a dominant health care system can result in price increases as high as 40-50 percent.¹² Furthermore, recent analyses suggest that hospital and physician payment rate increases are major contributors to rising premiums in large employer sponsored plans.¹³

B. Insurance Market Consolidation

Health insurance markets have also become increasingly concentrated in the last two decades. A 2013 study by David Emmons and Jose Guardado, for the American Medical Association (“AMA”), found that over 72 percent of all health insurance markets were highly concentrated.¹⁴ In 2014, the Government Accountability Office (“GAO”) assessed the concentration of private health insurers at the state level for the individual, small-group, and large-group insurance markets and found that in most states enrollment was concentrated among

⁶ David Cutler & Fiona Scott Morton, *Hospitals, Market Share, and Consolidation*, 810 JAMA 1964 (2013) [hereinafter *Hospitals, Market Share, and Consolidation*].

⁷ American Hospital Association, “TrendWatch Chartbook 2014: Trends Affecting Hospitals and Health Systems,” available at <http://www.aha.org/research/reports/tw/chartbook/>.

⁸ See *Hospitals, Market Share, and Consolidation*, supra note 3.

⁹ Medical Group Management Association, “Physician Compensation and Production Survey: 2011 Report Based on 2010 Data,” available at <http://www.mgma.com/Libraries/Assets/Industry%20Data/Survey%20Reports/Report%20Updates/Table-21-Physician-Specialty.pdf>.

¹⁰ William B. Vogt & Robert Town, “How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?” *Robert Wood Johnson Foundation*, (Feb. 2006) [hereinafter *Hospital Consolidation*] available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056-subassets/rwjf12056_1; Martin Gaynor & Robert Town, “The Impact of Hospital Consolidation—Update,” *Robert Wood Johnson Foundation*, (Jun. 2012), available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.

¹¹ Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation—Update*, ROBERT WOOD JOHNSON FOUNDATION (Jun. 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.

¹² Martin Gaynor, *Competition Policy in Health Care Markets: Navigating the Enforcement and Policy Maze*, 33 HEALTH AFF. 1088 (2014) [hereinafter *Competition Policy in Health Care Markets*].

¹³ Robert A. Berenson, et al., *The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed*, 31 HEALTH AFF. 973 (2012) (internal citations omitted).

¹⁴ David W. Emmons & Jose R. Guardado, “Competition in Health Insurance: A Comprehensive Study of U.S. Markets,” AM. MED. ASS. (2014).

the three largest insurers.¹⁵ In 37 states, the three largest insurers held 80 percent or more of the market share in each of the three insurance market segments.¹⁶ As Professor Leemore Dafny testified before the Senate Judiciary Committee last week, the national four-firm concentration ratio, which measures the market share of the four largest insurance firms for private insurance, increased from 74 percent to 83 percent from 2006 to 2014.¹⁷

At present, the five largest health insurers are UnitedHealth Care, Anthem, Cigna, Aetna, and Humana. If these mergers go forward, the three largest remaining insurance companies would cover approximately 131 million Americans and 40 percent of the private market.¹⁸ The loss of Humana and Cigna would dramatically alter the health insurance landscape and raise significant competitive concerns for private health insurance markets throughout the country.¹⁹

II. Merger Review

As a result of their size and scope, the DOJ will review the proposed mergers to ensure they comply with the federal antitrust laws, including Section 7 of the Clayton Act, which prohibits mergers and acquisitions whose effect “may be substantially to lessen competition, or to tend to create a monopoly.”²⁰ According to the Horizontal Merger Guidelines (“the Guidelines”) jointly issued by the DOJ and Federal Trade Commission (“FTC”), the guiding principle for merger review is that “mergers should not be permitted to create, enhance, or entrench market power or to facilitate its exercise.”²¹ To that end, the review process seeks to determine whether a proposed transaction “is likely to encourage one or more firms to raise price, reduce output, diminish innovation, or otherwise harm customers as a result of diminished competitive constraints or incentives.”²² In other words, beyond price increases and quality reductions, the DOJ and FTC (“the Antitrust Agencies”) are concerned with mergers that may enhance market power or facilitate its misuse.²³ Ultimately, the Antitrust Agencies are primarily concerned with the merger’s impact on consumers.²⁴

For the Proposed Mergers at hand, the DOJ must assess whether the deals are likely to enhance market power and thereby harm competition and consumers. This process is predictive, and it is, of course, impossible to know for certain exactly how the deals might play out in the

¹⁵ Government Accountability Office, “Private Health Insurance: Concentration of Enrollees Among Individual, Small Group, and Large Group Health Insurers from 2010-2013,” available at <http://www.gao.gov/products/GAO-15-101R>.

¹⁶ *Id.*

¹⁷ Leemore Dafny, “Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant In Light of the ACA, and What Should We Ask?” United States Senate Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights, Sept. 22, 2015 [hereinafter Dafny Statement] available at <http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf>.

¹⁸ Richard Pollack, “Testimony of the American Hospital Association,” United States Senate Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights, Sept. 22, 2015 [hereinafter Pollack Statement] available at <http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Pollack%20Testimony.pdf>.

¹⁹ AMA Wire, “States Where Health Insurers Are Squeezing Out Competition,” available at <http://www.ama-assn.org/ama/ama-wire/post/states-health-insurers-squeezing-out-competition>.

²⁰ Section 7 of the Clayton Act, as amended, 15 U.S.C. § 18.

²¹ U.S. Dep’t of Justice & Fed. Trade Comm’n, “Horizontal Merger Guidelines (2010),” at 2 [hereinafter 2010 Horizontal Merger Guidelines] available at <http://www.justice.gov/atr/public/guidelines/hmg-2010.html>.

²² *Id.*

²³ *Id.*

²⁴ *Id.*

future. The merger review process is, by definition, in the FTC's words, "forward-looking: it bars mergers that *may* lead to harmful effects."²⁵ In analyzing the deals, the DOJ will conduct a fact-specific inquiry, bringing to bear "a range of analytical tools to the reasonably available and reliable evidence,"²⁶ as part of a process guided more by principles than by rules. As part of that process, the DOJ will, in no set order, (1) study the various product and geographic markets at issue through the process of "market definition"; (2) consider evidence of adverse competitive effects from a range of sources; and (3) consider evidence of efficiencies likely to be achieved through the merger. Any evidence of efficiencies offered by the merging firms is subject to intense scrutiny, and, above all, competition and the impact on consumers—not the firms' internal operational efficiencies—will be given primacy in the DOJ's determination.²⁷

A. Markets at Issue

A central focus of the merger review process is market definition. Market definition plays two roles here: (1) it serves to identify the line of commerce and area of the country in which the competitive concern arises (required under the Clayton Act); and (2) it helps the Antitrust Agencies to identify market participants and measure market shares and market concentration. Market shares and market concentrations are not ends in themselves, but the process of measuring them is useful in illuminating the merger's likely competitive effects. Analysis of the product markets will likely include the impact of the mergers at the local, state and national levels. Here, as Professor Thomas L. Greaney testified before the House of Representatives, "[u]nravelling the extent of current competition between the merging parties will require a careful investigation of overlapping business in a number of distinct insurance product markets including those serving: individuals and small groups; Medicare Advantage beneficiaries; large fully insured employers; self-insured employers; and perhaps others."²⁸

Due to Humana's extensive Medicare Advantage portfolio, the DOJ will be taking an especially close look at that market. Medicare Advantage was designed to control costs and promote quality by creating a competitive market for private insurance plans as an alternative to traditional Medicare. Medicare Advantage plans are private managed care plans, approved by the government, that offer a wider array of benefits and lower cost sharing than traditional Medicare, in exchange for restrictions that are not present in traditional Medicare, such as utilization review, primary care gatekeeping, and a limited provider network.²⁹ Currently, Medicare Advantage has its highest enrollment ever, with 28 percent of all Medicare beneficiaries participating in a Medicare Advantage plan, and its popularity is continuing to grow.³⁰

²⁵ U.S. Dep't of Justice & Fed. Trade Comm'n., "Guide to the Antitrust Laws: Mergers," available at <https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/mergers>.

²⁶ See 2010 Horizontal Merger Guidelines, *supra* note 22, at 1.

²⁷ *Id.* at 31.

²⁸ Thomas L. Greaney, "The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition," United States House of Representatives Committee on the Judiciary, Subcommittee on Regulatory Reform, Commercial and Antitrust Law, at 9, Sept. 10, 2015 [hereinafter Greaney Statement] available at http://judiciary.house.gov/_cache/files/0a0e88c8-0519-4a47-8fa8-4c2233c760c3/greaney-testimony.pdf.

²⁹ Anna D. Sinaiko & Richard Zeckhauser, *Medicare Advantage – What Explains Its Robust Health?* 3 AM. J. OF MANAGED CARE (forthcoming) available at <http://www.hks.harvard.edu/fs/rzeckhauser/Medicare%20Advantage.pdf>.

³⁰ *Id.*

Because they compete for the same consumers initially, the question of whether Medicare Advantage should be considered a separate product market from traditional Medicare will likely be debated. The merging parties might propose a broader product market definition that includes both traditional Medicare and Medicare Advantage so as to appear to have less market share or potential market power.

Although all Medicare beneficiaries have a choice between Medicare Advantage and traditional Medicare, for antitrust purposes, one should not assume that these programs make up the same product market. Professor Greaney argued that “Medicare Advantage plans likely constitute a distinct product market because of the way private plans compete for inclusion in local markets and the distinct benefits they offer.”³¹ The DOJ will examine Medicare Advantage and other product markets with a focus on demand substitution factors, such as whether consumers can and will substitute another product in response to a price increase or reduction in quality or service.³²

Preliminary research into demand substitution suggests that Medicare Advantage enrollees prefer Medicare Advantage plans to traditional Medicare and do not view the two programs as equal alternatives. A recent study by health economists Anna Sinaiko and Richard Zeckhauser found that when a Medicare Advantage plan was eliminated and enrollees were forced to actively select another Medicare Advantage plan or default into traditional Medicare, the majority overrode the default and actively selected back into a remaining Medicare Advantage plan.³³ This finding suggests that the product market for Medicare Advantage plans can be differentiated from the product market for traditional Medicare, such that maintaining competition among Medicare Advantage plans to promote quality and innovation is important. Further, this analysis comports with the DOJ’s recognition in prior health insurance mergers that private insurance companies compete in the Medicare Advantage market to offer enhanced benefits at lower costs to enrollees, as opposed to the larger Medicare market.³⁴

The Medicare Advantage market is one of several markets to be considered in the merger review process; I highlight it here due to its importance for these mergers, as well as to illustrate the market definition process.

B. Adverse Competitive Effects

In addition to defining the relevant markets, the DOJ will also examine the potential adverse competitive effects of the proposed merger. As part of this analysis, DOJ will examine whether the merged entities are likely to exercise market power to the detriment of their consumers. This can be done in several ways: most obviously through price increases; but also by diluting quality and service; and very importantly by living what economists call the “quiet life” and refraining from innovating or entering new markets.³⁵

1. Potential to Raise Premiums

³¹ See Greaney Statement, *supra* note 29, at 9.

³² See 2010 Horizontal Merger Guidelines, *supra* note 22, at 7.

³³ Anna D. Sinaiko and Richard Zeckhauser, *Persistent Preferences and Status Quo Bias Versus Default Power: The Choices of Terminated Medicare Advantage Clients*, Unpublished Working Paper, Harvard University, 2015.

³⁴ See, e.g., Complaint, *United States v. UnitedHealth Group, Inc.*, No. 08-cv-322 (D.D.C. 2008).

³⁵ See 2010 Horizontal Merger Guidelines, *supra* note 22, at 2.

The potential to raise premiums over time presents one of the greatest risks associated with the Proposed Mergers. Historically, consumers have fared poorly in consolidated insurance markets.³⁶ The research on past insurance mergers reveals that insurers can and do exercise newly acquired market power by raising premiums.³⁷ An examination of the 1999 Aetna and Prudential Health Care Insurance merger estimated that health insurance consolidation between 1998 and 2006 led to a 7 percent increase in large group health insurance premiums.³⁸ Further, analysis of the UnitedHealth Group and Sierra Health Services merger increased the post-merger premiums in the Nevada markets by 13.7 percent, suggesting that the merging parties exploited the market power gained from the merger.³⁹ As Professor Dafny stated in her testimony to the Senate last week:

“If past is prologue, insurance consolidation will tend to lead to lower payments to healthcare providers, but those lower payments will not be passed on to consumers. On the contrary, consumers can expect higher insurance premiums.”⁴⁰

Furthermore, early data from the individual health care marketplaces also support the notion that increased competition among insurers is associated with lower premiums in the post-ACA landscape.⁴¹ One study found that the addition of one insurer would lower premiums by 5.4 percent, while adding every available insurer would lower rates by 11.1 percent.⁴² These findings suggest that the potential for these insurance companies to leverage gains in market power to raise premiums following these mergers is quite high.

Some observers have suggested that the Medical Loss Ratio (“MLR”) requirement established by the Affordable Care Act (“ACA”) will ameliorate any potential increase in premiums or other harms arising from consolidation. The MLR reduces the risk of unrestrained profit generation from an insurance merger by requiring insurers to spend a minimum of 85 percent (80 percent in the individual and small group markets) of premium revenue on clinical services and quality improvement. If an insurance company fails to meet the MLR standard, it must issue rebates to the enrollees in the relevant market. The MLR has had a positive effect on insurance markets. In the first year that the MLR was required, the median insurer increased its medical loss ratio from 74.8 to 80.3 percent.⁴³ Between 2011 and 2013, the MLR produced over

³⁶ See Dafny Statement, *supra* note 18; David A. Balto, *Health Insurance Merger Frenzy: Why DOJ Must Just Say 'No,'* LAW360 (Aug. 19, 2015) <http://www.law360.com/articles/683500/health-insurance-merger-frenzy-why-doj-must-just-say-no>.

³⁷ Leemore Dafny, *Are Health Insurance Markets Competitive?*, 100 AM. ECON. REV. 1399 (2010).

³⁸ See *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, *supra* note 4.

³⁹ Jose R. Guardado *et al.*, *The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra*, 1 HEALTH MANAGEMENT, POL'Y & INNOVATION 16 (2013).

⁴⁰ See Dafny Statement, *supra* note 18, at 9.

⁴¹ See *id.* at 13; Leemore Dafny *et al.*, *More Insurers Lower Premiums: Evidence From Initial Pricing in the Health Insurance Marketplaces*, AM. J. OF HEALTH ECON. 53 (Winter 2014) [hereinafter *More Insurers Lower Premiums*]; Michael J. Dickstein, *et al.*, *The Impact of Market Size and Composition on Health Insurance Premiums: Evidence from the First Year of the Affordable Care Act*, 105.5 AM. ECON. REV. 120 (2015) (estimating that an additional insurer in a given ratings area, results in savings of nearly \$500 per person).

⁴² See *More Insurers Lower Premiums*, *supra* note 42.

⁴³ J.M. Abraham, P. Karaca-Mandic, and K. Simon, *How Has the Affordable Care Act's Medical Loss Ratio Regulation Affected Insurer Behavior?*, 52 MED. CARE 370 (2014).

\$5 billion in savings for consumers, \$2 billion in rebates and \$3 billion in reduced insurer overhead.⁴⁴

However, as Professor Dafny stated in her testimony last week, the argument that the MLR will adequately protect consumers from anticompetitive harms arising from insurance mergers is unconvincing.⁴⁵ Rather than repeat all of her points here, I will just reiterate the three that involve the greatest risks to consumers. First, the MLR does not apply to enrollees in self-insured plans, who represent more than half of private insurance market, leaving those individuals still at risk of significant premium increases. Second, to constrain costs and promote quality of care, the MLR relies on the assumption of a competitive market. In a competitive market, insurers constrained by the MLR must compete for consumers on the basis of quality of care, network, and customer service. In the absence of competition, an insurer has little incentive to improve quality or innovate because its profit margin will remain the same. Third, the MLR may be “gameable” in ways that reduce consumer welfare. For example, in markets characterized by a dominant provider and a dominant insurer, the MLR may encourage a dominant insurer to agree to a dominant provider’s demands for supra-competitive rates because the insurer’s 20 percent administrative share will increase with larger medical spending. In sum, the MLR does not guarantee that dominant insurers will not raise premiums and as such, it is not a substitute for the pressures toward lower costs and higher quality created by a competitive market.

Overall, consumers bear the brunt of the impacts of consolidation in health care in multiple ways. When provider prices increase from consolidation in the provider market, insurance premiums follow.⁴⁶ When insurance markets consolidate, premiums also tend to increase.⁴⁷ When premiums go up, employers pass the cost through to employees in the form of reduced pay, higher cost sharing, or reduced benefits.⁴⁸ If past is not prologue, and merging insurance companies do pass through any beneficial price reductions obtained from providers, if the savings are obtained via monopsony power, consumers may still be harmed by reductions in the quality and quantity of provider services.⁴⁹ Further, consolidation may compromise opportunities to increase and sustain competition.

2. Reduction in Quality and Innovation

To be sure, employers and individuals buying health insurance are concerned about premiums, but they also are affected by the diminution of competition. Clearly, if the merged insurers keep premiums the same or even lower them, but compensate by reducing quality, or foregoing innovation, the merger will negatively affect consumers. For instance, insurance companies could reduce quality in numerous ways: delay or refusal to pay claims, poor

⁴⁴ Michael J. McCue & Mark A. Hall, *The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 3*, THE COMMONWEALTH FUND (Mar. 2015), available at <http://www.commonwealthfund.org/publications/issue-briefs/2015/mar/medical-loss-ratio-year-three>.

⁴⁵ See Dafny Statement, *supra* note 18, at 14.

⁴⁶ See *Competition Policy in Health Care Markets*, *supra* note 13; Richard Scheffler, E.R. Kesler, and M. Brandt, *Covered California: The Impact of Provider and Health Plan Market Power on Premiums*, J. OF HEALTH POLITIC, POL’Y & L. (forthcoming 2015).

⁴⁷ Kate Ho & Robin S. Lee, *Insurer Competition in Health Care Markets*, NBER, Working Paper No. 19401 (Sept. 2013), available at <http://www.nber.org/papers/w19401>; See *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, *supra* note 4.

⁴⁸ See *Competition Policy in Health Care Markets*, *supra* note 13, at 33.

⁴⁹ See Dafny Statement, *supra* note 18, at 10.

responsiveness to customers, inadequate and poor quality provider networks, lack of access to claims information, and mishandling of appeals, to name a few. In addition, there is some risk in fragmented provider markets that a dominant insurer could suppress reimbursement rates to such a level that providers sacrifice quality and output.⁵⁰ Although, research suggests this risk is significantly less likely in markets with more powerful provider organizations.⁵¹ Finally, as discussed above, both the Medicare Advantage program and the MLR rely on competition to maintain and promote quality when profits are regulated. In the absence of meaningful competition, the Medicare Advantage plans and plans subject to MLR constraints may have little incentive to improve quality of care.

3. Loss of Potential Competition

The proposed mergers may also harm consumers by stifling competition even in markets where there is little to no overlap in plans between the merging parties.

a. Potential to Diminish Market Entrance

First, the mergers may diminish the merging companies' interest in entering into new markets and increasing competition. Prior to the proposed mergers, there was some evidence that these insurers were considering expanding their presences in the state health marketplaces by offering plans in new states.⁵² The reduction in large insurers interested in entering the state marketplaces could undermine competition and cost-containment efforts in the exchanges.

The potential impact on competition in Medicare Advantage markets also raises substantial cause for concern.⁵³ Unfortunately, competition in most Medicare Advantage markets has been sparse, with 97 percent of counties with more than 10 Medicare Advantage enrollees exceeding the Merger Guidelines for high concentration (HHI > 2,500).⁵⁴ In fact, only one county in the country (Riverside, CA) meets the Guidelines' standard for an unconcentrated market, and only just barely.⁵⁵ While Medicare Advantage markets in both urban and rural areas are highly concentrated, the concentration in rural areas is exceptionally high (avg. HHI > 5,000).⁵⁶ Consolidation would enable a large insurer without a strong presence in the Medicare Advantage

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² See Greaney Statement, *supra* note 29, at 10; Bruce Japsen, *With Insurer Expansions in 2015, More Obamacare Choices, Competition*, FORBES (Aug. 3, 2014), available at <http://www.forbes.com/sites/brucejapsen/2014/08/03/more-obamacare-choices-competition-with-insurer-expansions-in-2015/>.

⁵³ Paul Ginsburg, "Hearing on 'Examining Consolidation In the Health Insurance Industry and Its Impact on Consumers'," United States Senate Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights, at 4, Sept. 22, 2015 [hereinafter Ginsburg Statement] available at <http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Ginsburg%20Testimony3.pdf>; Brian Biles, Giselle Casillas, and Stuart Guterman, *Competition Among Medicare's Private Health Plans: Does it Really Exist?*, THE COMMONWEALTH FUND, (Aug. 25, 2015), [hereinafter *Competition Among Medicare's Private Health Plans: Does it Really Exist?*] available at <http://www.commonwealthfund.org/publications/issue-briefs/2015/aug/competition-medicare-private-plans-does-it-exist>.

⁵⁴ See 2010 Horizontal Merger Guidelines, *supra* note 22, at 2; D. Altman, "Amid Merger Talk, a Look at Health Insurers' Medicare Business," *Washington Wire*, (Jul. 1, 2015), available at <http://blogs.wsj.com/washwire/2015/07/01/amid-merger-talk-a-look-at-health-insurers-medicare-business/>.

⁵⁵ See *Competition Among Medicare's Private Health Plans: Does it Really Exist?*, *supra* note 54.

⁵⁶ *Id.*

⁵⁷ *Id.*

market to gain a significant foothold. For example, as Mr. Bertolini noted in his Senate testimony, for Aetna, the merger is “primarily about Medicare” and gaining a substantial presence in that market.⁵⁷ As a result, preventing the merger could stimulate market entry by larger insurers into the Medicare Advantage market and promote competition.

b. Existing Contractual Restraints on Competition

Prior contractual relations between the merging firms and other entities may restrict market expansion or entry. For instance, risk to competition in all product markets that may arise from these mergers involves the potential that Anthem’s relationship with the Blue Cross and Blue Shield Association. As noted by Professor Greaney’s Testimony and Senator Michael Lee’s questions in prior hearings on this topic, the merger may limit Anthem/Cigna from expanding its business outside the “Blue” trademark and could require the removal or divestiture of Cigna plans in certain markets.⁵⁸ I am confident that this is an issue that the DOJ will explore extensively in its investigation of that merger’s impacts.

c. Relationships Between Dominant Insurers, Providers and Employers

Further concentration in the insurer market may lead to relationships between dominant insurers and dominate provider organizations that disadvantage rivals and harm consumers. As noted above, in theory, health insurers with market power have greater ability to negotiate lower prices from dominant provider organizations, which would benefit consumers and competition if those savings were passed on to consumers. However, there is no evidence that this actually happens. Instead, history provides several examples of dominant insurers and providers joining forces to disadvantage rivals and increase premiums and reimbursement rates.⁵⁹ For instance, in Allegheny County, PA, the dominant provider, the University of Pennsylvania Medical Center (UPMC), agreed to use its market power to prevent competitors of the dominant insurer, Highmark, from successfully entering or expanding in the Allegheny County market and, in exchange, Highmark agreed to use its position to strengthen UPMC and weaken its rivals.⁶⁰ These agreements represent classic attempts to foreclose competitors from the market. As Professor Greaney posits in his “Sumo Wrestler Theory Fallacy,” when dominant insurers and

⁵⁷ Mark T. Bertolini, “Prepared Statement,” United States Senate Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights, Sept. 22, 2015, [hereinafter Bertolini Statement], available at <http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Bertolini%20Testimony.pdf>.

⁵⁸ Professor Greaney Testimony, “The State of Competition In the Health Care Marketplace: The Patient Protection and Affordable Care Act’s Impact on Competition: Hearing, United States House of Representatives, Committee on the Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law, Sept. 10, 2015, available at <http://judiciary.house.gov/index.cfm/hearings?ID=417B9E62-CB8D-4EC7-905D-40F39B91E5E7>; Senator Michael Lee Question, “The State of Competition In the Health Care Marketplace: The Patient Protection and Affordable Care Act’s Impact on Competition: Hearing, United States House of Representatives, Committee on the Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law, Sept. 10, 2015, available at <http://judiciary.house.gov/index.cfm/hearings?ID=417B9E62-CB8D-4EC7-905D-40F39B91E5E7>.

⁵⁹ See, e.g., *West Penn Allegheny Health Sys., Inc. v. UPMC, Highmark, Inc.*, 627 F.3d 85 (3rd Cir. 2010); see also Complaint, *U.S. v. Blue Cross Blue Shield of Michigan*, 2:10-cv-15155 (E.D. Mich., 2010).

⁶⁰ See *West Penn Allegheny Health Sys.*, *supra* note 62. UPMC first offered Highmark a truce in 1998, but Highmark rejected it. Initially, Highmark stated that the offer was an illegal “attempt to form a ‘super’ monopoly for the provision of health care in Western Pennsylvania in which [UPMC], the leading provider of hospital services, and Highmark, the leading health insurer, would combine forces.” Four years later, Highmark changed its position on the offer and accepted it.

dominant providers face off, the result may be “a handshake rather than an honest wrestling match.”⁶¹

C. Post-Merger Efficiencies

As part of the merger review process, the DOJ will also consider evidence of any cognizable post-merger efficiencies offered by the merging companies.⁶² To reiterate, the efficiencies given weight are those that enhance competition, not just the internal operations of the firms involved.⁶³ As described in the Guidelines, in this analysis, the DOJ will only credit “merger-specific” efficiencies, meaning only those efficiencies unlikely to be accomplished without the proposed merger or another means with similar anticompetitive effects.⁶⁴ In addition, the efficiencies cannot be vague or speculative, and they cannot result from anticompetitive reductions in quality or output.⁶⁵ In short, to be cognizable, the efficiencies must be merger-specific, verifiable, and not achieved through anticompetitive means. If the DOJ identifies cognizable efficiencies in its merger review, it still must determine whether those efficiencies “are of a character and magnitude such that the merger is not likely to be anticompetitive in any relevant market.”⁶⁶ This bar is high, and more concerning mergers demand more mitigating efficiencies. As the Guidelines explain, “the greater the potential adverse competitive effect of a merger, the greater must be the cognizable efficiencies, and the more they must be passed through to customers.”⁶⁷ Accordingly, efficiencies are likely only to make a difference in a merger review in which the likely anticompetitive effects are small to begin with, and savings from those efficiencies will be passed on to consumers.

The merging companies will have the opportunity throughout the merger review process to present evidence of efficiencies to the DOJ. In the recent related Senate testimony, both Joseph Swedish, the President and CEO of Anthem, Inc., and Mark T. Bertolini, the Chairman and CEO of Aetna, Inc., each previewed the efficiencies that their respective companies hope to achieve through the proposed deals.⁶⁸ Although not specifically labeling them “efficiencies,” Mr. Swedish and Mr. Bertolini’s statements described a number of goals and benefits of the proposed deal including: (1) improving customer service, primarily through new or shared technology; (2) easing the transition from volume-based to value-based care; (3) extending provider networks and access to more products by consumers; and (4) leveraging complementary expertise.⁶⁹

First, as for efficiencies achieved through technology and other consumer engagement tools, the merging entities will have to demonstrate how such efficiencies would qualify as merger-specific. Consumer engagement tools identified in Mr. Swedish and Mr. Bertolini’s statements include apps that facilitate transparency, payment, and enrollment (Aetna); pre-existing transparency tools developed independently by Anthem and Cigna (Anthem); self-monitoring technology whose use would be promoted through discounts (Aetna); consumer questionnaires like the “Healthy Days” program conceived of by CMS and implemented by

⁶¹ See Greany Statement, *supra* note 24, at 11.

⁶² See 2010 Horizontal Merger Guidelines, *supra* note 29, at 2.

⁶³ *Id.* at 31.

⁶⁴ *Id.* at 30.

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.* at 31.

⁶⁸ See Bertolini Statement, *supra* note 59; see Swedish Statement, *supra* note 2.

⁶⁹ See Bertolini Statement, *supra* note 59, at 4-8; see Swedish Statement, *supra* note 2, at 3-5.

Humana (Anthem); and marketing materials like welcome videos prepared by merging firm (Anthem). The insurers will have to explain why these developments necessitate a merger. Apps, self-monitors, and marketing videos are typically inexpensive, and often the products of outsourced development, especially for non-technology businesses like health insurers. It is further unclear why implementing a customer questionnaire program created by the CMS would require a merger. As for pre-existing transparency tools that (according to their own leadership) work well for their distinct companies, it is unclear how the combination of such tools is merger-specific, or how much these tools—already touted as effective—would be improved through a merger.

Moreover, the Antitrust Agencies, and courts alike, have recently been skeptical of such technologies efficiencies claims. For example, in the FTC's recent challenge to the St. Luke's merger in Nampa, Idaho, St. Luke's failed to persuade the FTC, the district court, or the Ninth Circuit Court of Appeals that sharing electronic medical records ("EMRs") was a merger-saving efficiency. The Ninth Circuit explained that EMR technology sharing was not merger-specific because data analytics tools were equally available to all parties involved.⁷⁰ The DOJ may well have similar skepticism regarding the efficiencies claimed by the merging entities.

Second, the insurance companies claim that the merger will facilitate the transition to value-based payment models. This argument relies on the assumption that an insurer must attain a certain size in order to gain the economies of scale necessary to invest in delivery and payment system reform. Yet, there is no evidence that larger insurers are more likely to implement innovative payment and care management programs.⁷¹ Indeed, as Professor Dafny also noted in her Senate Testimony, "more dominant insurers in a given insurance market are less concerned with ceding market share," and thus may even be less likely to be leaders in payment reform.⁷² It should be added here that, in light of payment reform incentives in the ACA and consumer demand, the transition to value-based care is inevitable, with or without these mergers. Indeed, both Mr. Swedish and Mr. Bertolini emphasized the changing nature of health care markets, focusing on delivery and payment reform, as a central element of their testimonies. In other words, these transitions must occur with or without the merger.

Third, the insurers assert that consumers may gain access to a larger network of providers or more products offered by the consolidated insurers. Unlike those considered above, these efficiencies are likely merger-specific, in that combining the merging entities' networks and products may be the only or best means to offering them all to more consumers. However, it is not necessarily a benefit to consumers to expand the provider networks if it comes at a cost to choices and premiums. Nevertheless, even if these efficiencies proved cognizable, they still would have to be sufficient to transform an otherwise anticompetitive merger to a competitive one.⁷³ Again, this is a high bar, and, as the Ninth Circuit explained in *St. Luke's*, it is insufficient to show that the merged entity would better serve its customers; an efficiency must be shown to reverse a merger's anticompetitive effects.⁷⁴ On the information available, I am skeptical that the insurance companies could clear this high hurdle.

⁷⁰ *St. Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 791 (9th Cir. 2015).

⁷¹ See Dafny Statement, *supra* note 4.

⁷² *Id.*

⁷³ See 2010 Horizontal Merger Guidelines, *supra* note 22.

⁷⁴ See *St. Luke's*, at 791.

D. Remedies

Following its in-depth analysis of the potential pro- and anticompetitive effects of the proposed mergers on competition and consumers, the DOJ will decide whether to permit the mergers to continue, try to negotiate a settlement that places conditions on the mergers, or challenge the merger in court. Negotiated settlements that require divestitures are significantly more common than outright opposition to the merger. Given the scope of the proposed health insurance mergers and the vast array of both product and geographic markets affected, it is likely that DOJ approval, if given at all, will require divestitures in markets with significant overlap between the merging firms. Any decision to require a divestiture will require a very fact-specific investigation into the market dynamics of each specific market in question.

Although it's premature to speculate on whether divestitures are appropriate in this case, if the AMA/AHA indications are valid regarding the number of affected markets, numerous divestitures may be required.⁷⁵ As a result, I want to raise three points for consideration. First, academics and the Antitrust Agencies have recently expressed a great deal of skepticism that divestitures will remedy a proposed merger's likely anticompetitive effects. A recent study by John Kwoka concluded that divestitures often fail to fully restore competition.⁷⁶ Furthermore, despite required divestitures in both instances, the retrospective studies of the Aetna-Prudential merger and the UnitedHealth-Sierra merger found significant premium increases.⁷⁷ On the government side, despite Sysco's multiple divestitures, the FTC recently filed suit to challenge its proposed \$3.5 billion merger with US Foods, which eventually led to the parties abandoning the deal. Also, the FTC announced plans to study whether divestiture requirements and other remedies the agency demands of merging entities are producing the desired results.⁷⁸ I hope that the Antitrust Agencies will bring the results of this study, even if they are only preliminary, to bear on their decision regarding divestitures in these mergers.

Second, I want to reiterate Professor Greaney's point that successful divestiture requires identifying an appropriate entity to purchase the assets that can provide a network of hospitals and physicians that can compete in the market on cost and quality.⁷⁹ Identifying and monitoring these replacement entities across the span of overlapping markets will be a significant challenge, if feasible at all.

Third, the nature of mergers in the United States, for better or for worse, is that once they are complete, they tend to stay that way. The relative permanence of a decision to approve the Proposed Mergers as well as the sheer impact on competition throughout the U.S. health care markets of losing two of the five largest health insurers markets demands a great deal of caution and skepticism.

⁷⁵ American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, 2015 Update, available at https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product_id=prod2680007&navAction=push#usage-tab; Pollack Statement, *supra* note 19.

⁷⁶ John Kwoka, *MERGERS, MERGER CONTROL, AND REMEDIES: A RETROSPECTIVE ANALYSIS OF U.S. POLICY*, MIT PRESS (2015).

⁷⁷ See, *supra* notes 38 and 39.

⁷⁸ Fed. Trade Comm'n, "FTC Proposes to Study Merger Remedies: Effort Would Enhance 1999 Divestiture Study," (Jan. 9, 2015), available at <https://www.ftc.gov/news-events/press-releases/2015/01/ftc-proposes-study-merger-remedies>.

⁷⁹ See Greaney Statement, *supra* note 29, at 12.

III. Beyond Antitrust Enforcement

By design, our health care markets rely on competition to control costs and promote quality. Yet, they lack so many attributes of efficient competitive markets. More can be done to foster competition and promote efficient functioning in healthcare. First, rather than acquiescing to further consolidation among insurers to offset provider leverage, more should be done to constrain the growth and limit the abuses of provider market power. Doing so will require attacking the problem from multiple fronts, including: 1) increasing competition by removing barriers to entry and broadening the scope of provider practice; 2) increasing the transparency of health care prices in strategic ways;⁸⁰ 3) passing laws to prohibit anticompetitive provisions in plan-provider contracting (e.g., Most Favored Nation and Anti-Tiering/Anti-Steering provisions); and 4) vigorous enforcement of existing antitrust laws, including a willingness to use structural remedies to subdivide dominant entities that repeatedly abuse their market power.

Second, if consolidation of health care insurance and provider markets continues apace, controlling costs may require additional regulatory oversight in all private markets.⁸¹ State governments have a key role to play in this arena. For instance, a recent study found that states with stronger rate review authority and loss ratio requirements more successfully constrained health care costs than states that did not.⁸² If the Proposed Mergers are permitted to go through and premiums rise, this could fuel calls for strengthened rate review initiatives, both broader in scope than existing ones and with more regulatory authority to disapprove unreasonable rate increases. States can also contribute to controlling health care costs by requiring all health care payers and providers to report health care claims data to a state database to facilitate analysis of health care expenditures, inform research on the efficacy of policies aimed at constraining costs and promoting competition, and promote price transparency efforts.

Conclusion

What is at issue in this hearing is more than just the fate of Aetna, Humana, Anthem, or Cigna, and it is more than just the fate of competition in health care markets throughout the United States. When we talk about whether the proposed mergers will lead to increased premiums or result in lower quality care, we need to remember that what we are really talking about is Americans' ability to pay their bills, care for their loved ones, and overcome an illness. Every year, millions of Americans struggle to pay their health insurance premiums, their deductibles, and their coinsurance. They decide between putting healthy food on the table and health insurance, or between heating oil and health insurance, or between advancing their or their children's education and health insurance, or between investing in their retirement and health insurance. We should do all that we can to ensure that the money spent on health insurance provides maximum value to those who choose to invest in it.

⁸⁰ See, Morgan A. Muir, Stephanie Alessi, and Jaime S. King, *Clarifying Costs: Can Increased Price Transparency Reduce Healthcare Spending?*, 4 WILLIAM & MARY POL'Y REV. 319 (2013).

⁸¹ Erin C. Fuse Brown, *Resurrecting Health Care Rate Regulation*, 67 HASTINGS L. J., 66-67 (forthcoming 2015).

⁸² Pinar Karaca-Mandic, Brent D. Fulton, Ann Hollingshead, and Richard M. Scheffler, *States With Stronger Health Insurance Rate Review Authority Have Experienced Lower Premiums in the Individual Market in 2010-2013*, 34 HEALTH AFFAIRS 1358 (2015).

Mr. MARINO. Thank you.
Mr. Haislmaier?

**TESTIMONY OF EDMUND F. HAISLMAIER, SENIOR RESEARCH
FELLOW OF HEALTH POLICY STUDIES, THE HERITAGE
FOUNDATION**

Mr. HAISLMAIER. Mr. Chairman, thank you, Members of the Committee, as well, for inviting me to testify today.

In response to the Committee's invitation, I conducted an analysis, which I have presented in my written testimony, of the markets for the respective products of these companies. I will simply make a few observations here in my oral testimony, most of which are also in my written testimony.

My analysis used enrollment data, looking at all of the country by State. It was divided for geographic presence—I give the reasons for that—and also by product line. This is for the comprehensive insurance market.

There are five market segments. I looked at individual, fully ensured employer group coverage, Medicare Advantage, self-insured employer group plans for which an insurer provides only administrative services, and Medicaid managed care.

In looking at the specific mergers, as I noted, nationally, 40 percent of Humana's business is in the Medicare Advantage line. That is 40 percent of their total enrollment. When you look at the two companies on a national level, it seems fairly obvious to me that Aetna's acquisition of Humana is principally about acquiring Humana's Medicare Advantage business. It has been noted by others, I believe, when you combine those two companies, the net position would be that the company would have 25 percent, roughly, of the national market. That, of course, will vary substantially by State. I break out in the table the State variation.

One of the points that I make in the table and in the testimony is that in most States, the effect even in that market will be relatively small. There are some notable examples of exceptions, where both carriers have a substantial presence already in the Medicare Advantage market that would be made even bigger.

Aside from Medicare Advantage, my analysis found few other places that would result in any significant additional concentration in other States or product lines. The one exception being Georgia, where Humana already has 58 percent of the individual market, and merging the two would bring that up to 65 percent.

But by and large, there is not a lot of overlap, as you can see in the table.

With respect to Anthem's proposed acquisition of Cigna, one needs to start by understanding the unique features of each company. Eighty-four percent of Cigna's covered lines are administrative services for self-insured employer plans. In fact, I have a Cigna card because my employer is self-insured and uses Cigna.

Anthem, however, is a collection, really, of 14 Blue Cross plans. So in those States where Anthem operates a Blue Cross plan, virtually anything Anthem does in terms of an acquisition will take a big insurer and make it bigger. There is almost no way to escape that, and that is true in the self-insured market, in this example.

Outside of those 14 States, though, I found very little evidence that there would be any significant impact. In most States, there would be no impact whatsoever because Anthem simply lacks a presence and, as I said, Cigna's presence is so concentrated in one market subset.

Beyond that, I also looked at another acquisition, which I thought we were going to talk about—I will briefly mention that—of Centene's acquisition of HealthNet. That is simply, as I describe in the testimony, an insurer expanding its footprint. HealthNet only operates in four States, and Centene does not operate in three of those four with any significant presence.

Now Chairman Goodlatte had mentioned and I was asked to comment on some of those effects that might be behind this from the Affordable Care Act. I do believe some of those provisions in the Affordable Care Act may be responsible for some of the thinking behind the mergers. Certainly, the Affordable Care Act makes the administrative services business for fully insured employer plans a more attractive business for the insurer. That is also likely to grow as employers attempt to evade the cost-increasing mandates in the Affordable Care Act.

The other problem, of course, is that a lot of what the Affordable Care Act does is to limit choice and competition in standardization to treat insurance like a commodity and insurers like commodity producers. So from that perspective, it is not terribly surprising that you would see insurers behaving like commodity producers or regulated utilities and merging for scale.

Mr. Chairman, thank you for the opportunity to testify. I hope the information I presented is helpful to the Committee in understanding the markets involved and the companies involved. I would be happy to answer any questions.

[The prepared statement of Mr. Haislmaier follows:]



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CONGRESSIONAL TESTIMONY

**Effects on Competition of Proposed
Health Insurer Mergers**

**Testimony before
Committee on the Judiciary
Subcommittee on Regulatory Reform,
Commercial and Antitrust Law
United States House of Representatives**

September 29, 2015

**Edmund F. Haislmaier
Senior Research Fellow
The Heritage Foundation**

Mr. Chairman and members of the committee, thank you for inviting me to testify. My name is Edmund F. Haislmaier and I am a Senior Research Fellow in Health Policy at the Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

My testimony today will focus on the potential effects on market competition of three, currently pending, health insurance mergers, specifically: 1) Aetna's acquisition of Humana; 2) Anthem's acquisition of Cigna, and; 3) Centene's acquisition of Health Net.

To assess market competition in any industry one must begin by identifying the parameters of the relevant market, or markets. In the case of health insurance, two key parameters are geographic presence and product line.

Geography is a relevant parameter for a couple reasons. First, because most medical services are purchased locally, the prices and quantities of those services, the size and distribution of the patient population, and the contractual arrangements of insurers and providers, can all vary by location. Variations in those inputs affect the price of coverage and the extent of insurer competition available to consumers. Second, the regulation of insurance, including most anti-trust regulation, has historically been the responsibility of state governments.

Product line is also a relevant parameter because within the broader market for health insurance there exist discrete submarkets with different types of customers. Thus, the business strategy of any given insurer might range from targeting only a single subset of the broader market to seeking to serve multiple submarkets by offering a number of different product lines.

Consequently, applying these two parameters offers an appropriate framework for segmenting the broader market before analyzing the relevant data to evaluate competition within each subset.

I have limited my analysis to those submarkets for what is commonly known as "comprehensive" or "major medical" health insurance coverage—setting aside various so called "supplemental" product lines, such as dental only or vision only coverage. My reasons for doing so were first, that there is greater public interest in market competition with respect to comprehensive medical coverage, and second, that potential barriers to competition and market entry are much lower for supplemental products, and thus of rather less concern to both consumers and regulators.

I used enrollment, or the number of "covered lives," as the basis for measuring market share. While various financial metrics are relevant to assessing whether a proposed merger is a wise business decision, those metrics would tell us little about the effects that the merger might have on the choices available to consumers.

Thus, for my analysis I used enrollment data taken from insurer regulatory filings for the end of 2014, distributed in a matrix consisting of five submarkets in each state.

Those five market segments are: 1) individual coverage; 2) fully insured employer group coverage; 3) Medicare Advantage plans; 4) self-insured employer group plans for which insurers provide administrative services only, and; 5) Medicaid managed care.

The first three submarkets—individual, fully insured group, and Medicare Advantage—are ones for which competition is most appropriately measured at the state level. Each one serves a distinct subset of customers, yet in all three markets the customers purchase coverage locally.

In contrast, the markets for self-insured group coverage and Medicaid managed care are more national in character and the customers—large employers and state governments—are more sophisticated purchasers.

The self-insured employer coverage market consists primarily of large employers and such firms are not limited by geography when contracting with vendors to manage their plans. Indeed, a major reason that many large employers self-insure is that the arrangement enables them to offer a uniform plan to workers located in multiple states.

Similar to self-insured employer plans, Medicaid managed care typically takes the form of “bulk” contracts between state governments and insurers—though unlike self-insured employer plans, it is typically the insurer, not the plan sponsor, that bears most of the risk under a Medicaid managed care contract. As with self-insured employer plans, there is no inherent geographic limitation to carriers bidding for Medicaid managed care contracts.

That said, while competition in these two segments may be national in scope from the customer perspective, these arrangements do affect the competitive dynamics with respect to medical providers at the state or local level. That is because insurance carriers must still contract with local providers to fulfill those contracts. Thus, as a practical matter, the extent of a given insurer’s provider contracting in a particular state will affect its ability to compete for the business of self-insured employers and state Medicaid agencies. Also, from the provider perspective, the total number of covered lives across all of a given insurer’s product lines can affect the relative bargaining positions of providers and insurers. In other words, it is possible for either competitive extreme to exist: a locally dominant provider system with near-monopolistic leverage over insurers, or a locally dominant insurer with near-monopsonistic leverage over providers.

With that as background, let me turn to offering specific data and comments about each of the three pending mergers.

Aetna’s Proposed Acquisition of Humana

Because Humana’s principle business line is Medicare Advantage plans—accounting for 40 percent of the company’s total enrollment nationwide—Aetna’s acquisition of Humana largely represents an expansion of Aetna’s presence in that submarket. Nationally, as of the end of 2014, Humana was the second largest Medicare

Advantage carrier while Aetna was the fourth largest. Combining the two companies would position Aetna as the largest Medicare Advantage carrier, though it would still have less than 25 percent (24.6 percent) of the total national market for that product line.

Table 1 summarizes my analysis of the state level effects of this proposed merger. In most states the consolidation effect on the Medicare Advantage market would be fairly modest. Even in states where one of the companies already has a substantial share of the market, combining the two would, in most cases, have the marginal effect of adding only a few percentage points of market share.

The exceptions are the handful of states where both carriers already have significant shares of the Medicare Advantage market. Most notably, in Kansas each company already has more than 40 percent of the Medicare Advantage market and the combined company would have an 86 percent share. In both Iowa and Missouri one company currently has more than 30 percent market share with the other having more than 20 percent, so that the combination would produce market shares of almost 58 percent and 52 percent, respectively. Similarly, in both Ohio and Nebraska each company currently has more than 20 percent market share and the combination would produce market shares of 47 percent and 45 percent, respectively.

With respect to the other four market segments in this analysis, Table 1 shows that the state level consolidation effects would be modest, or even marginal, in almost all instances. The one notable exception is Georgia, where Humana already has 58 percent of the individual market—increasing to 65 percent under the proposed merger—and where the two companies each have about 18 percent of the fully insured employer group market, yielding a post-merger 36 percent market share.

Anthem's Proposed Acquisition of Cigna

Because Cigna's principle business consists of providing administrative services for self-insured employer plans—accounting for 84 percent of Cigna's total enrollment nationwide—Anthem's acquisition of Cigna consists almost entirely of an expansion of Anthem's presence in that submarket.

Yet, while Anthem is one of the largest carriers nationally, its geographic presence is much narrower than those of its peers. That is because Anthem is principally a collection of Blue Cross plans in 14 states. Because of their long histories, at the state level Blue Cross carriers tend to occupy dominant market positions in most or all subsets of the broader health insurance market. Thus, in the 14 states where Anthem owns a Blue Cross subsidiary, the company already has dominant market positions that are almost certain to be further expanded when it acquires any competitor, regardless of the target company's business focus. In its basic structure, Anthem is most similar to Health Care Services Corporation, which is a nonprofit, member-owned, mutual insurer comprised of Blue Cross plans in 5 states.

Consequently, it is not surprising that Table 2 shows that the main effect of Anthem acquiring Cigna would be to further expand Anthem's dominance of the market for administrative services for self-insured employer plans in the 14 states where the company owns a Blue Cross carrier. The same would also hold true for the fully insured employer group market in three of those fourteen states: Indiana, Maine and New Hampshire. However, beyond that, as Table 2 shows, this merger would have little or no market consolidation effect in other states or other market segments.

As I previously noted, the market for administrative services for self-insured employer plans is the most "national" of the five market segments and is characterized by sophisticated purchasers with few geographic constraints. Thus, state level dominance by a single carrier is of less concern in this particular submarket, at least from the perspective of the customers for those services. However, as I also noted, such consolidation would concern medical providers to the extent that more of their patients are enrolled in plans administered by a single carrier.

Centene's Proposed Acquisition of Health Net

Ninety percent of Centene's total enrollment is from Medicaid managed care contracts in 15 states. Health Net operates in only four West Coast states: Arizona, California, Oregon and Washington, and in two to four market segments in each state—though California is the only state where Health Net has Medicaid managed care. In contrast, Washington is the only one of those four states where Centene has a significant presence (in Medicaid managed care). Thus, this acquisition essentially consists of Centene expanding its geographic "footprint" to include Arizona, California and Oregon. Because of the lack of overlap between the two companies, in none of the five market segments in any of those four states would this merger produce even one percentage point of market consolidation.

Additional Observations

From the perspective of a market analyst there appear to be likely rationales for each of these three proposed mergers.

Given steadily growing enrollment in Medicare Advantage plans, particularly among younger and newly eligible beneficiaries, Aetna's decision to expand into that market by acquiring Humana makes sense. In essence, Aetna is looking to acquire more business in a segment of the market with good prospects for future growth.

The self-insured employer market is a large one that has also been growing steadily at rate of about two percent per year. Some provisions of the Affordable Care Act, most notably the extension—starting next year—of the law's costly essential benefit requirements to employer groups of 100 or fewer workers, may also induce a further shift among mid-sized employers from fully insured to self-insured plans. Thus, it does not seem surprising that Anthem would want to expand further into that market by acquiring Cigna.

While Centene's acquisition of Health Net can be viewed, as an expansion of Centene's geographic footprint there may also be another, ACA related, factor at work. Centene was one of two multi-state Medicaid managed care companies (the other being Molina) that went into the ACA exchanges in those states where they had Medicaid managed care contracts. Those companies recognized that the design of the ACA's tax credits and cost sharing subsidies were likely to produce an exchange market consisting mainly of heavily subsidized low-income customers in plans with only nominal patient cost sharing—in short, a market that looked very much like their existing Medicaid managed care business. That has indeed proven to be the case, and may be part of the explanation for Centene's interest in acquiring Health Net, which is already on the exchanges in Arizona and California and also has 332,000 Medicaid managed care enrollees in California.

Mr. Chairman, this concludes my prepared testimony. I thank you for inviting me to testify today. I will be happy to answer any questions that you or the other members may have.

Table 1
Aetna-Humana Merger: Pro Forma Market Share Analysis
 Using Enrollment by State and Product Line as of End of 2014

State	Individual	Fully Insured Employer Group	Medicare Advantage	Self-Insured Employer Group	Medicaid Managed Care
AK	DM	NE	DM	NE	NE
AL	DM	DM	DM	NE	NE
AR	DM	DM	36.3 + 6.3 = 42.6%	NE	NE
AZ	4.9 + 3.4 = 8.3%	14.3 + 6.1 = 20.4%	14.4 + 1.4 = 15.8%	DM	NE
CA	DM	DM	1.8 + 1.1 = 2.9%	NE	NE
CO	DM	4.5 + 3.6 = 8.1%	13 + 1.4 = 14.4%	DM	NE
CT	DM	NE	DM	NE	NE
DC	DM	NE	DM	NE	NE
DE	DM	NE	43.3 + 5.4 = 48.7%	NE	NE
FL	18.3 + 15.6 = 33.9%	20 + 7.9 = 27.9%	37.2 + 5.5 = 42.7%	DM	12.4 + 2.7 = 15.1%
GA	57.8 + 7.1 = 64.9%	18.7 + 17.2 = 35.9%	8 + 22 = 30%	DM	NE
HI	NE	NE	DM	NE	NE
IA	DM	NE	33 + 24.8 = 57.8%	NE	NE
ID	DM	NE	DM	NE	NE
IL	4.2 + 3.4 = 7.6%	5 + 3.9 = 8.9%	23.7 + 13 = 36.7%	7.2 + 1.2 = 8.4%	9.9 + 2.1 = 12%
IN	DM	DM	31.7 + 3.7 = 35.4%	11.5 + 2 = 13.5%	NE
KS	30.9 + 2.3 = 33.2%	15 + 5.4 = 20.4%	44.9 + 41.4 = 86.3%	DM	NE
KY	13.7 + 5.1 = 18.8%	DM	71.5 + 2.3 = 73.8%	29.6 + 3.4 = 33%	27.6 + 8.7 = 36.3%
LA	8.7 + 4.1 = 12.8%	DM	DM	6.6 + 3.4 = 10%	NE
MA	DM	NE	DM	NE	NE
MD	DM	NE	23 + 1.2 = 24.2%	NE	NE
ME	DM	NE	29.2 + 6.7 = 35.9%	NE	NE
MI	6.6 + 1.3 = 7.9%	DM	10.2 + 1 = 11.2%	DM	NE
MN	DM	NE	DM	NE	NE
MO	DM	18.8 + 2.9 = 21.7%	31.2 + 20.5 = 51.7%	DM	NE
MS	DM	1.7 + 1.4 = 3.1%	61 + 1.1 = 62.1%	2.5 + 1.1 = 3.6%	NE
MT	NE	NE	DM	NE	NE
NC	DM	DM	23.6 + 4.1 = 27.7%	NE	NE
ND	NE	NE	NE	NE	NE
NE	DM	NE	23.1 + 22.1 = 45.2%	DM	NE
NH	DM	NE	20 + 3 = 23%	NE	NE
NJ	DM	NE	DM	NE	NE
NM	NE	NE	DM	NE	NE
NV	5 + 1.7 = 6.7%	6 + 1.4 = 7.4%	31.5 + 4.5 = 36%	NE	NE
NY	DM	NE	DM	NE	NE
OH	3 + 4.3 = 7.3%	7.1 + 5.4 = 12.5%	20.1 + 27.4 = 47.5%	14.8 + 2.4 = 17.2%	NE
OK	DM	DM	26.7 + 2.5 = 29.2%	NE	NE
OR	DM	NE	DM	NE	NE
PA	DM	NE	20.9 + 3.5 = 24.4%	NE	NE
RI	NE	NE	DM	NE	NE
SC	DM	DM	38.4 + 1.7 = 40.1%	NE	NE
SD	NE	NE	28.3 + 7.4 = 35.7%	NE	NE
TN	DM	8.7 + 2.8 = 11.5%	31.4 + 1 = 32.4%	3 + 1.2 = 4.2%	NE
TX	12 + 3.2 = 15.2%	11.7 + 8.6 = 20.3%	23.3 + 12.7 = 36%	25.7 + 1.6 = 27.3%	NE
UT	20.5 + 5.6 = 26.1%	13.8 + 1.4 = 15.2%	13.5 + 8.2 = 21.7%	NE	NE
VA	DM	DM	58.1 + 3.3 = 61.4%	NE	5.7 + 1.7 = 7.4%
VT	NE	NE	DM	NE	NE
WA	DM	DM	DM	NE	NE
WI	NE	DM	DM	7 + 3 = 10%	NE
WV	DM	NE	62.8 + 10.5 = 73.3%	NE	NE
WY	DM	NE	9.7 + 4.2 = 13.9%	NE	NE

Key: NE = No Effect. One or both companies had no enrollment.

DM = De Minimis. Enrollment for one or both companies was less than either one percent of the market or 100 covered lives, or both.

Table 2
Anthem-Cigna Merger: Pro Forma Market Share Analysis
 Enrollment by State and Product Line as of End of 2014

State	Individual	Fully Insured Employer Group	Medicare Advantage	Self-Insured Employer Group	Medicaid Managed Care
AK	NE	NE	NE	NE	NE
AL	NE	NE	DM	NE	NE
AR	NE	NE	NE	NE	NE
AZ	NE	NE	8.8 + 3.9 = 12.7%	NE	NE
CA	33.5 + 2.3 = 35.8%	17.5 + 2.5 = 20%	DM	45.3 + 12 = 57.3%	NE
CO	17 + 8.3 = 25.3%	17.8 + 5.4 = 23.2%	NE	37.9 + 21 = 58.9%	NE
CT	DM	24.4 + 9.7 = 34.1%	NE	28.7 + 21.4 = 50.1%	NE
DC	DM	NE	NE	NE	NE
DE	NE	NE	DM	NE	NE
FL	6 + 2.5 = 8.5%	NE	DM	NE	NE
GA	17.6 + 1.3 = 18.9%	27 + 4.7 = 31.7%	DM	54.7 + 16.3 = 71%	NE
HI	NE	NE	NE	NE	NE
IA	NE	NE	NE	NE	NE
ID	NE	NE	NE	NE	NE
IL	NE	DM	DM	NE	NE
IN	DM	50.9 + 1 = 51.9%	DM	39 + 20 = 59%	NE
KS	NE	NE	NE	NE	NE
KY	DM	DM	NE	53.2 + 2.7 = 55.9%	NE
LA	NE	NE	NE	NE	NE
MA	NE	DM	NE	7.6 + 5.1 = 12.7%	NE
MD	DM	NE	NE	NE	NE
ME	NE	53.1 + 3.6 = 56.7%	NE	43.4 + 5.7 = 49.1%	NE
MI	NE	NE	NE	NE	NE
MN	NE	NE	NE	NE	NE
MO	DM	31.3 + 1 = 32.3%	NE	25.3 + 14.6 = 39.9%	NE
MS	NE	NE	NE	NE	NE
MT	NE	NE	NE	NE	NE
NC	NE	NE	DM	NE	NE
ND	NE	NE	NE	NE	NE
NE	NE	NE	NE	NE	NE
NH	DM	49.3 + 6.4 = 55.7%	NE	55.8 + 16.7 = 72.5%	NE
NJ	DM	NE	NE	NE	NE
NM	NE	NE	NE	NE	NE
NV	NE	DM	NE	17.2 + 11.1 = 28.3%	NE
NY	DM	7 + 5.2 = 12.2%	NE	26.9 + 8.5 = 35.4%	NE
OH	NE	DM	NE	50.9 + 8 = 58.9%	NE
OK	NE	NE	NE	NE	NE
OR	NE	NE	NE	NE	NE
PA	NE	NE	DM	NE	NE
RI	NE	NE	NE	NE	NE
SC	NE	NE	DM	NE	NE
SD	NE	NE	NE	NE	NE
TN	NE	NE	23 + 1.6 = 24.6%	NE	NE
TX	5.2 + 3.8 = 9%	NE	10 + 3.3 = 13.3%	NE	20.9 + 1.3 = 22.2%
UT	NE	NE	NE	NE	NE
VA	NE	36.1 + 4.7 = 40.8%	NE	56.2 + 15.7 = 71.9%	NE
VT	NE	NE	NE	NE	NE
WA	DM	NE	NE	NE	NE
WI	NE	DM	NE	48.1 + 3 = 51.1%	NE
WV	NE	NE	NE	NE	NE
WY	NE	NE	NE	NE	NE

Key: NE = No Effect. One or both companies had no enrollment.

DM = De Minimis. Enrollment for one or both companies was less than either one percent of the market or 100 covered lives, or both.

Mr. MARINO. Thank you.

I will now recognize myself for 5 minutes of questions, and my colleagues will then follow.

Mr. Bertolini, some time ago we heard testimony that insurance policies are becoming narrower and, as a result, consumers end up paying more for the services or drug out-of-pocket expenses, et cetera. Would you comment on this potential trend and how your merger would impact the breadth and services of drugs covered under your policies?

Mr. BERTOLINI. Thank you, Mr. Chairman, for your question.

As I mentioned earlier, health care premiums are not established in the abstract. They are directly related to the underlying costs. So in places where we have narrower plan designs or narrower networks, those are designed to try to impact the cost of care. And largely, the people who buy those policies are the people who are using those providers already and using those services. So it relies on broader breadth of product across multiple competitors in order to be able to provide enough services for everybody in a market. But when we look at the people who choose our plans, particularly on the public exchanges, they are choosing our plans because they are using those providers and they need the benefits that we cover.

Mr. MARINO. Thank you.

Mr. Swedish, can you respond to that also?

Mr. SWEDISH. Yes. I will maybe take a little different tack in that we work very collaboratively with the physician community, particularly focusing on buildout of provider collaboration models.

A great example is our pursuit of value-based payment methodologies. In doing so over the last couple of years, now 53 percent of our payment to providers is based on value—i.e., outcome-driven. In that regard, in answer to your question, together with the provider community, we are looking at building out more affordability for our members, particularly in the area of controlling drug spend, which is escalating at a phenomenal rate.

Just last year, you know that pharma pricing increased 13 percent. We believe that is escalating year over year.

So, again, working in collaboration with providers in a value-based arena, we believe we can demonstrate increasing affordability to our members.

Mr. MARINO. I am going to stick with you for a moment, Mr. Swedish. I am from a very rural area, the 10th Congressional District of Pennsylvania, a lot of farm people, a lot of blue-collar workers. What impact is your merger going to have on the cost of health care for these individuals, and accessibility?

Mr. SWEDISH. Absolutely, thank you, Mr. Chairman.

There are three main elements regarding the combination of two companies that are very complementary. The core elements are affordability, access, and the pursuit of increased quality, quality of safety, quality related to service. In that regard, we believe that the combination will translate especially to affordability as our two organizations, number one, leverage the combined assets, especially in and around data access, creating better health care analytics, and then build out evidence-based protocols with our provider partners; and number two, then what savings we can create in terms

of efficiencies of operations. Those savings then will go to the consumers by way of better premium support.

Mr. MARINO. Thank you.

Mr. Haislmaier, as you heard, I represent a very rural area, and I continually hear from my constituents, physicians, hospitals, that Obamacare is just driving the price up astronomically to the point where some of the hospitals and physicians believe they cannot stay in business and my constituents cannot afford the payments associated with that.

I know you talked a little bit about how Obamacare does have an impact. Would you expand on that somewhat, please?

Mr. Haislmaier. Well, the legislation subsidizes some people, but the number of people it subsidizes is only a fraction of the number of people whose coverage was artificially—the cost of which was artificially increased by regulation.

So in other words, I did this analysis separately a few months ago, and we published it in connection with the court case, and we did it by State, I should say, too. But when you look at the number of people in the individual and small group markets that are subject to the ACA regulatory requirements that drive up the cost of coverage, that number is about three times the number of people who actually got a subsidy to offset those increases. In other words, only about one-quarter of the population that the additional costs were imposed on actually qualifies for a subsidy through the exchange to help them with it.

So I think what you are hearing from your constituents are those other people who are small-business owners typically or individuals who are self-employed who make too much money to get a subsidy on the exchange who are complaining because they saw their premiums go up, but they did not get any help with paying for that extra cost.

Mr. MARINO. Right. Thank you.

My time has expired. The Chair now recognizes the Ranking Member, the gentleman from Georgia, Congressman Johnson.

Mr. JOHNSON. Yes, thank you.

Mr. Haislmaier, to what do you attribute the decline in double-digit premium increases in this country over the past few years?

Mr. Haislmaier. I am sorry?

Mr. JOHNSON. To what do you attribute the decline in the double-digit premium increases?

Mr. Haislmaier. Decline in double-digit premium increases?

Mr. JOHNSON. Yes.

Mr. Haislmaier. In what sector, sir?

Mr. JOHNSON. So you do not recognize that premiums costs, the rate of escalation in premium growth has declined since the passage of the Affordable Care Act?

Mr. Haislmaier. Well, no, actually, it has not. My colleague has done data on that that we published on premiums. I would be happy to have him share it with you, but it all has been published on the growth in premiums.

Mr. JOHNSON. Okay, thank you.

Mr. Nickels, Mr. Bertolini has testified that there are new market entrants, including providers, that are offering health insurance products that produce meaningful competition to health insur-

ance companies, and that is one of the reasons why they would justify the merger. What is your response to that?

Mr. NICKELS. Yes, it is correct that there are more hospitals coming into the market. Although to refer to that statistic, I think there were 15 new hospital plans in the last 3 years, so that is not a huge number. But there are some that are coming in. Some are interested. Consumers are interested in these kinds of options.

But again, we are at the infancy stage here, and these plans pale in comparison to the size of these potential mergers.

So is it a positive step? Yes. But it should not be used to justify these mergers because, again, these are fragile entities that are just getting into the market right now.

Mr. JOHNSON. All right, thank you.

Mr. Bertolini, several of your fellow witnesses cite a Commonwealth Fund study published last month that found that 97 percent of Medicare Advantage markets are highly concentrated and characterized by a lack of competition. What is your response to that finding?

Mr. BERTOLINI. Congressman Johnson, I can only comment on the data that we have about the markets that we are in. In those markets, after the acquisition, 8 percent of Medicare beneficiaries will select our products. Ninety-two percent will not. In markets where we have nonrural areas, 18 competitors, and in rural areas, 10 competitors, we continue to see people entering the market. And our comment around 15 being provider-owned is not about whether or not they justify the mergers, but they do justify the fact that barriers to entry are not as high as others would comment, and it is rather lower barriers to entry, as a result of the opportunities afforded by government-funded programs like Medicare Advantage.

Mr. JOHNSON. Okay. Thank you.

Professor King, all the way through Emory University just outside of my district, welcome.

Ms. KING. Thank you.

Mr. JOHNSON. I would like to ask you, why is the medical loss ratio insufficient to guarantee that premiums will not be raised after consolidation? You explained it, but I want you to put a little bit more meat on that explanation.

Ms. KING. Absolutely. So the medical loss ratio is a key tool toward constraining insurer premiums and insurer profits and keeping the cost to health care down. But it is insufficient on its own, especially in the absence of competition, to maintain costs in this market and promote quality.

So medical loss ratio, first of all, does not apply to about half of the privately insured individuals in the market who get their insurance from self-insured providers.

Mr. JOHNSON. Okay, I understand.

Ms. KING. So if it does not apply to them, then premiums can go up, and it is not going to protect them.

Mr. JOHNSON. A merger, a consolidation, would lead to those self-insured plans—

Ms. KING. Being exposed to higher premium increases. That is right.

Mr. JOHNSON. All right. Let me stop you.

Do you, Mr. Swedish, or you, Mr. Bertolini, disagree with that?

Mr. SWEDISH. Yes, sir, I would like to address that for just a moment.

There is a complementary nature in the combination of our two companies. The fact is that Cigna presents a very large engagement in the administrative services only marketplace, meaning that we are supporting very large employers in national accounts. Those are the organizations that demand that level or type of service and product offerings.

We believe that what is critically important for the Committee to understand is that there are many competitors in that space; number two, that these are highly sophisticated buyers of administrative service only arrangements; number three, because it is ASO, the savings go back to the employer.

What is fascinating is that what we have found with respect to large employers is that there are at least 130 unique health benefit companies serving that sector of the marketplace. In 2014, there were 30 new companies competing in that market. Finally, the GAO report found that an average of 11 insurers compete for large group customers.

So in any event, we believe it is highly competitive and, quite frankly, serves that marketplace very well, in terms of the competitive environment that we function in.

Mr. JOHNSON. Thank you. I yield back.

Mr. MARINO. Thank you.

The Chair now recognizes the gentleman from Georgia, Congressman Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

This is a concern for me, and I know the Chairman has spoken to this, being from a rural area. But there is also the issue of mergers and also leverage and nonleverage. The people at the bottom of the line who get caught in this are the actual folks who are your customers and also customers, frankly, of the hospitals and doctors, as well. It is not good—like in my district, we have had this happen on a couple of occasions—when the two are not able to negotiate. So we end up sending out letters to 38,000 and 40,000 people saying teachers in your area will not be able to use your local hospital because we cannot come to a satisfactory agreement. Although they are covered for the entire year, their contracts do not overlap with the hospitals, so insurance companies and hospitals negotiate on a different timetable than actually was sold, the policy, which, again, no one, frankly, understands.

I have been listening to this debate today. The really interesting part, Mr. Bertolini and Mr. Haislmaier note in testimony that Humana has 58 percent of the individual market in Georgia and that number is expected to rise to 65 percent after the merger closes.

Tell me why I should not be concerned about this level of concentration and how we can ensure consumers not only in Georgia, but I am concerned that the Ninth District of Georgia has a sufficient number of insurers to choose from in this process.

Mr. BERTOLINI. Thank you, Congressman, for your question.

The market currently has 10 competitors and choices for people to choose from, so concentration is one measure of whether or not there is a problem from a competitive standpoint, and we will co-

operate with the Department of Justice in reviewing that opportunity and those issues.

In regard to your comment about provider and health plan negotiations, I would state that the current fee-for-service payment system that causes providers and payers to have this conversation is why our health care costs are so high. Unless we change that dynamic to a different payment model focused on outcomes and on whole case and improving the health of individuals, this kind of dynamic will only continue and will leave the member in the middle.

Mr. COLLINS. I think they are already left in the middle. I do want to continue on that, and I understand that there are choices, but those choices seem to be narrowing more and more, especially with the different plans. When you get to a market share of close to 65 percent, that does tend to at least look like you are cutting off avenues, especially where there is a possibility of not being able to buy across State lines and other things like that, you are taking an area—I mean, in this hearing just recently, we talked about this. It is not just this market but the PBM market, which I have a great deal of problems with because basically they are bent on destruction and killing the independent pharmacies.

But as we look at this, why would this not be a concern? I know there are options out there, but do you understand the perception from the community that there is? I agree with you on outcome. I agree with you that we need to change some of the cost systems here. But when we look at this, I mean, Aetna and Humana are going to have 36 percent of the fully insured market in my area.

I am just trying to get a grip on how you can explain that as being good when we, frankly, see problems in this all the time.

Mr. BERTOLINI. Obviously, we have a Department of Justice review going on. To the degree that divestitures are required, we will make those.

So we understand that there are some markets, a handful or so of markets where we have this kind of overlap that we are prepared to deal with appropriately. Most often, what we see happening now is that provider systems buy these capabilities from us when we decide to divest them.

So I think we can actually create more competitors as a result of this combination.

Mr. COLLINS. Okay.

Mr. Haislmaier, would you like to respond to that?

Mr. Haislmaier. No, I think that is a fair characterization. I was simply pointing out the extent to which concentration did or did not exist, Georgia being an example outside of Medicare Advantage where this merger would produce concentration.

As Mr. Bertolini has said, that may be something that will be remedied by the State or Federal Government in insisting on a divestiture.

There is a much larger issue about competition that is not part of this hearing, which is sort of that the whole business model of everybody needs to be updated, but that would be a topic for another day.

Mr. COLLINS. I appreciate that, but I think it is part of this hearing. I think that is the issue. All companies, not just in this industry, there are others merging as well. You have a lot of good folks

sitting behind you and also outside this room who can tell the anti-trust, they can tell the letter of law. The problem many times is not, are we following “the letter of the law” in mergers? It is the actual effect on the market, the actual perceived effect on the market, when dealing with hospitals or dealing with doctors.

That is the concern that I have, the leverage issue. I have no problem with business models. They all change over time. But when you have a group that really is, frankly, at the mercy of the bigger players, and in my area that would be insurance companies and hospitals—you know the old proverb says, when elephants fight, the only thing that loses is the grass, okay? And the grass is the people that you serve.

I yield back.

Mr. MARINO. The Chair recognizes the Congressman from Michigan, the Ranking Member of the full Committee, Congressman Conyers.

Mr. CONYERS. Thank you, Mr. Chairman.

And I thank all the witnesses, too.

Professor King, I am going to ask you several questions, and then I have a couple for Dr. Gurman. So pick your responses. You do not have to try to cover everything in all of the question.

What are some of the negative effects of existing high levels of concentration in health care markets? Number two, what did studies of prior health insurance mergers reveal about their effects on competition? And why do you think the Department of Justice is keeping a close eye on the overarching impact of transactions for the entire health care system? And finally, is there any evidence that any savings from post-merger efficiencies are passed on to the consumers?

Take your choice.

Ms. KING. Okay. There is a lot there.

So in terms of negative effects of prior mergers, this is one of the things that the FTC and DOJ look at when they look at horizontal mergers. They look at what has happened in the past.

That is why Professor Leemore Dafny last week said that if past is prologue, here is what we anticipate that we will see.

There have been two retrospective studies that have looked at health insurance mergers. I am sure you have seen these. One looked at Aetna and Prudential, and the other looked at UnitedHealthcare and Sierra. Both of them found, in the wake of those mergers, that there were significant price increases. The Aetna-Prudential merger came down with 7 percent premium increases, and then the UnitedHealthcare and Sierra came down with almost 14 percent increases in premiums in the wake of those mergers.

One thing I want to emphasize about those mergers is that those were mergers where divestitures were used. So in those instances, it is not always easy to determine which markets are likely to see price increases and then target those appropriately.

They did use a divestiture in Texas in the Aetna merger, and they found that that was an effective divestiture in that space. But nonetheless, premiums did increase in numerous, numerous affected markets as a result of those.

So I think that is what we are seeing. We are also seeing in those mergers, in those prior mergers, that there was no impact on quality so quality of care did not increase. The promises that were made initially about how many improvements were going to happen and the things that the consumers were going to see as benefits in those spaces did not materialize.

Mr. CONYERS. Thank you so much.

Ed, write some more to put in the record on this, because I wanted to ask our Dr. Gurman before time runs out to explain how health insurers' monopsony power endangers the quality of health care available to consumers.

Mr. Bertolini and Mr. Swedish both contend that health insurance markets are flush with competition not only from traditional health insurance companies, but from new market entrants.

What is your response to those two questions?

Dr. GURMAN. Thank you, Mr. Conyers. First of all, it is an honor to dialogue with you.

The effects of mergers, which cause increased consolidation and not competition, are severalfold. As Professor Dafny said, the past is, unfortunately, prologue. So we have an ample historic record to show what has happened in the past.

When there is monopsony power exercised, what happens to physicians is that if they are paid less than competitive rates, there is a downstream effect on patients, because physicians do not have the financial resources to invest in infrastructure, to invest in technology, to invest in staffing, patient education, customer service aspects of medical care. And they spend less time with their patients because they are dealing with all of the other regulatory issues.

So the effect of monopsony is not only on physicians but it also is on patient care.

Mr. CONYERS. Thank you very much.

Let me close with this one question. Professor King, did the studies of prior insurance mergers reveal the effects of competition on consumers?

Ms. KING. They did. In terms of price and premium increases, they did. Are you asking about overall health of consumers and their outcomes?

Mr. CONYERS. Well, if the Chairman will let me squeeze it in, yes.

Mr. MARINO. Go ahead.

Ms. KING. I do not know of any studies. That is a great question, in terms of how their outcomes fared. But I know that overall quality of care in what was measured in those regards was not. There was no effect found.

Mr. CONYERS. Thank you so much. And I thank all the witnesses.

Mr. MARINO. The Chair now recognizes the gentleman from Texas, Congressman Ratcliffe.

Mr. RATCLIFFE. Thank you, Chairman.

As I noted in a recent hearing that we had in here on competition in the health care marketplace, the Texans that I represent have, in most cases, been adversely impacted and, in many cases, to a devastating extent, impacted by the perversely named Patient Protection and Affordable Care Act.

The folks in my district, certainly, have not found this law to provide affordable care or care that protects their interests with respect to choice, with respect to quality, with respect to cost.

Health care is incredibly personal, and I think we need to keep that in the forefront of our mind as we talk about these mergers today.

So conversations about the health care marketplace can get technical very quickly, so I want to begin with a very basic question for both Mr. Bertolini and for Mr. Swedish. I ask that you answer these quickly because I want to get to a number of questions.

So, Mr. Bertolini, in a nutshell, how do you think the merger between Aetna and Humana will benefit my constituents? In other words, specifically, how will it impact their premiums and their deductibles and the quality of care that they receive?

Mr. BERTOLINI. Thank you, Congressman Ratcliffe.

Our deal is largely a Medicare Advantage deal, so those prices are set by CMS and by the government, so we see no commercial impact in the State of Texas. So this is largely around prices that get set by the Federal Government, which have gone down 10 percent since 2010 while trend has grown up 20 percent. So we have actually created savings for those members through that time frame, those beneficiaries.

Mr. RATCLIFFE. Okay.

Mr. Swedish, same question for you.

Mr. SWEDISH. Certainly, thank you, Mr. Ratcliffe.

The combination, we believe, will lead to better value for consumers through three core elements: provider collaboration, consumer focus, and affordability.

The second point is that our combination is highly complementary in the sense that both geography and product focus is perfectly aligned in terms of maximizing the strengths of both companies in terms of how we are going to better serve the marketplace, whether it is small group, large group, the individual markets, other elements, core elements of the services we provide.

Finally, let me underscore that health care is unique, because it is highly localized, and there is a competitive nature in each one of those localized markets, which, obviously, we believe we will be a very effective competitor in those markets, bringing value to our members.

Mr. RATCLIFFE. Thank you, Mr. Swedish.

Dr. Gurman, do you want to comment on that? My question for you actually tied into that. The district I represent, the Fourth Congressional District of Texas, includes a very rural area, so I would like you to address how the proposed merger would affect quality and affordability of health care delivery, specifically in rural areas like many of the parts that I represent.

Dr. GURMAN. Thank you, Congressman.

First of all, in respect to what you said earlier, our analysis of the Aetna-Humana merger in the commercial market space says that for combined HMO-PPO and point of service plans, as well as in those individual considerations, that Texas is one of four States where there would be an effect. We are not talking about Medicare Advantage. This is commercial insurance. This is all in my written

testimony. I will be happy to follow up with your staff, if you need more information about that.

In response to your question regarding how this affects rural areas, I talked before in response to Mr. Conyers about the effect on patients. What happens, though, in consolidated markets, particularly when the consolidation goes to a company which is far away is that my ability to advocate on behalf of patients can be compromised. Every once in a while, you get a patient who has an unusual medical need, care need, whatever. When I talk to the medical director who is local, he knows that Andy Gurman is a reasonable guy who is dedicated to his patients, I hope he knows that, and we can have a discussion about what we are going to do, what resources we are going to mobilize, to take care of this patient's particular needs.

If the medical director that I am talking to is in Timbuktu somewhere as part of a megamerged conglomerate, I do not have that personal relationship and it becomes much harder to do that.

The other problem is that if there is severe monopsony or market control, narrow networks sometimes are a consequence with that. If I make too much noise, I may find that I am not in the network.

Mr. RATCLIFFE. Okay, thank you.

Mr. Haislmaier, I want to quickly get to you. One of the stated benefits of these mergers has been the efficiencies that are expected to reduce costs to customers, in particular. With respect to past health insurance mergers, do you have any data that supports whether or not the savings have actually been passed on to customers?

Mr. Haislmaier. No, I do not.

Mr. RATCLIFFE. So do you have any concerns that these mergers will present additional barriers of entry into the health care marketplace?

Mr. Haislmaier. As I pointed out in my testimony—

Mr. MARINO. The gentleman's time has expired, but you can, please, answer that question quickly.

Mr. Haislmaier. Thank you, Mr. Chairman.

As I pointed out in my testimony, I am not saying that these are great, and I am not saying that they are terrible either. I am saying that they are what they are. What they are is a combination of companies, and they do have more or less effect depending on the product line and the place where the combination is taking place.

Mr. RATCLIFFE. Thank you.

I yield back, Mr. Chairman.

Mr. MARINO. The Chair recognizes the gentleman from New York, Congressman Jeffries.

Mr. JEFFRIES. I thank the distinguished Chair, and I also want to thank the witnesses for your testimony here today.

Dr. Gurman, I believe on page 6 of your testimony, you cited a 2015 study by the Association of American Medical Colleges that the United States will likely face a physician shortage between 45,000 and 90,000 over the next 10 years. Is that correct?

Dr. GURMAN. That is correct, sir.

Mr. JEFFRIES. I think you also cite projections by the Department of Health and Human Services that suggest a similar shortage is

likely to occur of primary care physicians in the United States over that same time period. Is that right?

Dr. GURMAN. Yes, sir.

Mr. JEFFRIES. As we see the health insurance market consolidate and merge, what is your view as to how these mergers and consolidations are likely to impact what is anticipated to be a physician shortage across the country that I think many would find interesting to know is particularly acute in rural America?

Dr. GURMAN. Thank you for that observation. It is of great concern. It is of concern to me as I get older and I want to know who is going to take care of me. It is of concern because, as markets consolidate, there can be a detrimental effect on physicians and physician practices. This can influence the career choices that people make, either to go into medicine or, once in medicine, what specialties to take.

So our concern is that competition is better for patients, it is better for physicians, it is better for everybody, whereas consolidated markets give monopsony power to the insurers and makes it harder for the physicians and less attractive for physicians, particularly in primary care.

Mr. JEFFRIES. Thank you.

Professor King, I think you noted in your testimony that there is no evidence that savings or efficiency that result from these type of mergers in the past have resulted in those savings being transmitted to consumers. Is that correct?

Ms. KING. Yes, it is correct.

Mr. JEFFRIES. And that analysis is based on a study of mergers within the insurance industry that have taken place in the past. Could you elaborate on that?

Ms. KING. Yes, that evidence is based on Professor Dafny's research that she did several years ago, and also a 2015 study that came out by Trish and Herring, just recently in 2015. They found in that study that they were able to suppress or push down provider reimbursement rates, which, as we noted, can compromise quality in some instances, but that the increase in margins on insurance were almost exactly met, which means that provider insurance profits went up but there was no transferring back to payers.

Mr. JEFFRIES. Thank you.

Mr. Haislmaier, I believe in response to a previous question, you indicated that you are unfamiliar with any evidence that these savings have ever been passed on to consumers. Did I hear your testimony correctly?

Mr. Haislmaier. Yes, that is unfamiliar. That does not mean it does not exist. It just means I am not familiar with it.

Mr. JEFFRIES. Okay. But you are an expert in this industry.

Mr. Haislmaier. Yes, I think the question is really a bit off-topic because I am not expecting a great deal in the way of savings out of these mergers to start with. So saying, what do you do with the money that is saved, if there really is not a lot of savings? I mean, I am looking at these as really a lot of overlap where you are just consolidating two into one.

This is not dissimilar to previous mergers. I mean, Aetna in 2013 bought Coventry. There was very little overlap between those two companies. There were States where Coventry had a presence and

Aetna did not, and vice versa. We are not going to see much change.

Mr. JEFFRIES. But should there not be a reasonable expectation that to the extent these mergers are going to be evaluated by the Department of Justice, presumably to determine whether there would be some public benefit or public detriment, that there would be some benefit inured by the consumers that we on this panel and those Members of Congress throughout these hallowed halls represent?

Mr. HAISLMAIER. Well, the issue is not that they have to show benefit. The issue is, is there something detrimental about it? The presumption is that as long as there is nothing detrimental about it, you can go about doing your own business and dealing with whom you want and merging how you want.

The same is true on the hospital sector. I mean, look, this is kind of why I am in the middle here, because we have the monopsonists complaining about the monopolists, and the monopolists complaining about the monopsonists. I mean, you are looking at hospitals consolidating so that the insurer has no choice but to deal with one system.

So the issue from a regulatory consumer perspective is not whether they provide good. The issue is, do they do harm?

Mr. JEFFRIES. My time has expired. But I would just note in closing, Mr. Chair, if you would permit me, that the two companies that are before us today and these distinguished gentlemen, of course, these are publicly traded companies, which means they have a fiduciary obligation to their shareholders. And I think the notion that the mode of analysis should simply be whether it is likely to result in detriment to the public is a misplaced way to approach public policy here, and I respectfully yield back.

Mr. MARINO. The Chair now recognizes the gentleman from Rhode Island, Congressman Cicilline.

Mr. CICILLINE. I thank the Chairman, and I thank the witnesses for coming before the Subcommittee and sharing your perspectives this afternoon, and for providing your written testimony.

Given the size of the parties that are involved, these mergers will, of course, impact the lives of millions of Americans. It is very important that Members of this Committee fully investigate and evaluate the consequences that these proposed mergers will have on consumers, particularly, of course, the patients.

My sense is that, broadly speaking, the proponents of the mergers have claimed that the consolidation will result in a better consumer experience by providing improved quality of care and at a reduced cost. More specifically, this claim arises from the idea that the merged insurers will realize savings from increased efficiencies and will pass these savings on to consumers.

However, I must admit after reviewing the testimony, I am skeptical. If insurers are allowed to merge, they may, in fact, become more efficient, but the question really is, what evidence is there that these savings will be passed on to consumers and to patients? And what will be the impact on care?

As has been mentioned, Dr. Dafny of Northwestern University noted in her testimony before the Senate Judiciary Committee that if you look at the studies on insurance mergers that have occurred

already, they have led to increases in premiums even as many of these insurers pay lower rates to health care providers.

So what I am really interested to hear from Professor King, if you could begin, is there any evidence that mergers of this magnitude and in this sector will actually produce cost savings to the ultimate consumer or patient?

And to Mr. Haislmaier's point, even though there might be no evidence of detriment, is there any evidence of a benefit when the market shares are as big as these proposed mergers will result in?

Ms. KING. So to answer your first question, there is no evidence that these the savings in premiums are passed on to consumers. I looked really hard, and I found none.

In terms of a detriment, a potential detriment, all of this is always going to be predictive. The FTC and the DOJ have to look at this potential merger and decide, is it likely to increase market power or entrench market power in these ways? I think the things they are concerned with: Is it likely to increase premiums? Is it likely to result in a loss of quality or innovation? And is it likely to harm competition?

I think that what we have seen is that, historically, yes. Historically, prices are increased. Historically, we have seen no impact on quality in terms of it increasing or decreasing, but no evidence that it increases.

In terms of harm to competition, you have to think about the fact that we are hoping to promote entry into these markets. And Mr. Swedish and Mr. Bertolini have said how important it is to be in the Medicare Advantage market, how important it is to be in the self-insured national market. These are places they would like to expand and grow.

What they are doing is they are engaging in a merger to enter that space instead of entering it on their own and increasing competition in that space. I think that is something that we should really be thinking about. Is that a potential harm to competition, that instead of going into these areas on their own, they are attempting to acquire somebody who is already there and successful?

Mr. CICILLINE. Mr. Bertolini and Mr. Swedish both contend, at least in their written testimony, that health insurance markets are flush with competition not only from traditional health insurance companies, but from new market entrants, as you just mentioned, which include Accountable Care Organizations and other health care providers. Can you just respond to that assertion? Is that a sufficient safeguard against some of the concerns the Committee is expressing?

Ms. KING. Are you asking me?

Mr. CICILLINE. Yes.

Ms. KING. I am sorry. I thought you shifted. Can you ask the question again? I apologize.

Mr. CICILLINE. They both sort of make the argument that health insurance markets are flush with competition not only from traditional health insurance companies but from new market entrants, which include Accountable Care Organizations and other health care providers.

Ms. KING. Okay. So my sense of this is that we are definitely starting to see in certain markets, in the exchanges and in some

other spaces, new entrants. We are certainly starting to see that from integrated delivery systems and larger provider organizations.

But I am from California, and this is a little bit like saying we have had 2 rainy days and that is going to overturn the entire drought, right? It is not going to happen that way. This is encouraging. It is good to see new entrants into the market, but it is not by any stretch changing dramatically the amount of consolidation that we are seeing across the board.

Mr. CICILLINE. Thank you.

I yield back, Mr. Chairman.

Mr. MARINO. Seeing no other Congressmen or Congresswomen, this concludes today's hearing.

I want to thank all of our witnesses for attending.

Without objection, all Members will have 5 legislative days to submit additional written questions for the witnesses, or additional materials for the record.

The hearing is adjourned.

[Whereupon, at 2:38 p.m., the hearing was adjourned.]

A P P E N D I X

MATERIAL SUBMITTED FOR THE HEARING RECORD

**Response to Questions for the Record from Mark T. Bertolini,
Chairman and Chief Executive Officer, Aetna, Inc.**

**Aetna Responses to Questions for the Record
Subcommittee Chairman Marino**

**U.S. House of Representatives Committee on the Judiciary Subcommittee on
Regulatory Reform, Commercial and Antitrust Law**

**Subcommittee Hearing
“Healthy Competition? An Examination of the Proposed Health Insurance
Mergers and the Consequent Impact on Competition”
September 29, 2015**

1. Is your proposed merger motivated at all by, or in response to, consolidation among hospitals?
 - The primary goal of the Humana transaction is to enable the combined company to offer consumers a broader choice of products and access to higher-quality and more-affordable care.
 - We believe the combination will enhance our ability to work collaboratively with providers to create value based payment arrangements that result in better care to consumers. Both companies are focused on developing new tools and programs that strengthen the partnership between consumers and their providers, which will help us move toward a more value-based health care system.

We currently have # such ACOs in place and many others in the pipeline. One successful example of these arrangements is Innovation Health, an insurance product offered by Aetna and Inova in Virginia. Together we offer consumers premiums that are 3-5 percent lower than other network plans in the area. And we’ve improved health outcomes, including a 27 percent reduction in Cesarean-section admissions and 86 percent engagement in complex case management.
2. Certain parties have advanced criticisms of your proposed merger. For example, the AHA asserts that hospital mergers are fundamentally different than your proposed merger because your merger will have a more enduring impact. They additionally assert that even a modest price increase resulting from your proposed merger will lead to billions of dollars in additional consumer cost. Please provide any additional information regarding these assertions that would be helpful to the Committee’s evaluation of the related issues.
 - The primary goal of the Humana transaction is to enable us to offer consumers more affordable and higher quality care, available to more people, and with a broader choice of products.

- Over the first three years of the transaction, we expect to achieve \$1.25 billion in cost savings that will help Aetna become more efficient. We expect that a significant portion of these savings will flow back to consumers through more cost-effective products.
- Our goal is to remove waste and duplicative administrative costs and use some of the savings to develop products to keep people healthier. Today, health insurance is mostly about protecting from catastrophic costs. We want to move to products that consumers can rely on throughout the year and throughout their life to stay in good health.
- Another key consideration when considering potential impact on consumer cost is the fact that the health insurance industry is already highly regulated by both federal and state governments. The ACA has imposed a medical loss ratio limiting administrative costs and profits for most insurance products.
- Finally, remember that premium prices are driven by the underlying cost of hospital and doctor care and specialty drugs, which make up approximately 85 percent of all costs.

3. Both AHA and AMA have presented studies that assert your merger would result in market concentration levels that would “raise significant competitive concerns.” Please provide any additional information regarding these studies that would be helpful to the Committee’s evaluation of the related issues.

- Identifying and measuring the transaction’s impact on competition is a complex, fact intensive exercise and is a process we are working through with the Department of Justice as part of its investigation of Aetna’s proposed acquisition of Humana.

The AHA and AMA analyses obscure the fact this is a largely complementary deal that combines Aetna’s commercial expertise and Humana’s Medicare expertise. In the case of most products and geographies, there is little or no overlap between Aetna and Humana.. And even in areas where both offer some kind of product, there are often numerous competitors.

- For example, A combined Aetna and Humana will still account for
 - only 8 percent of Medicare enrollment, facing competition from 144 other competitors – including traditional Medicare and many provider owned plans and
 - 13 percent of commercial enrollment, facing competition from a number of firms,, including United, Anthem, HCSC, Cigna, Highmark, Centene, Carefirst, other local Blue Cross Blue Shield plans, Emblem Health, Kaiser, and provider-based plans. Moreover, on the eight public exchanges where Aetna and Humana both participate, there are on average 10 other insurers (at least 5 other participating issuers in each state). A growing number of employers also are turning to new private health care exchanges offered by large benefits consultants such as Towers Watson and Mercer.
-

- The AMA's analysis does not take into account the different product and customer focuses of Aetna and Humana. The AMA claims the transaction will lessen competition for commercial products in a number of areas where, in fact, Humana focuses on individual and/or small group fully-insured business but Aetna's business is largely attributable to large multi-site, self-insured customers. Because Aetna and Humana have distinct focuses in these different segments, the parties' offerings are largely complementary.
- Some critics, such as these, cite analyses of the HHI" index (Herfindahl–Hirschman Index). The FTC, DOJ, and the courts that have interpreted these issues have said that HHIs are merely an initial screen, not the end of the analysis. Antitrust analysis is about more than HHIs. This is a complicated process that we continue to work through with the DOJ. It involves a thorough analysis of documents, marketplace facts, competitors, new entrants, products, geographies, costs, prices, innovation, and efficiencies, among other things. HHIs do not address any of these issues.
- This transaction is subject to a lengthy, careful and thorough ongoing investigation by the Department of Justice and state Attorneys General.

**Response to Questions for the Record from Joseph Swedish,
President and CEO, Anthem, Inc.**



Elizabeth P. Hall
Vice President,
Office of Federal Government Affairs,
Anthem, Inc.

November 24, 2015

The Honorable Bob Goodlatte
Chairman
United States House of Representatives
Committee on the Judiciary
2138 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Goodlatte:

On behalf of Mr. Joe Swedish, President and Chief Executive Officer of Anthem, Inc., enclosed please find Anthem's responses to questions for the record from the Committee's September 29th hearing entitled "Healthy Competition? An Examination of the Proposed Health Insurance Mergers and the Consequent Impact on Competition." We appreciate the opportunity to respond.

Sincerely,

A handwritten signature in black ink, appearing to read "E. Hall".

Elizabeth P. Hall
Vice President

Office of Federal Government Affairs
Anthem, Inc.
1001 Pennsylvania Ave. NW
Suite 710
Washington, DC 20004

U.S. House of Representatives Committee on the Judiciary
Subcommittee on Regulatory Reform, Commercial and Antitrust Law

Hearing on
“Healthy Competition? An Examination of the Proposed Health Insurance Mergers and the
Consequent Impact on Competition”

September 29, 2015

Questions for the Record

Questions submitted for the Record from Subcommittee Chairman Tom Marino

1. **Anthem is a licensee and provider of Blue Cross Blue Shield insurance plans. The licensing agreement includes a provision that requires Anthem to have two-thirds of its income from Blue Cross Blue Shield products. Cigna is not a Blue Cross Blue Shield licensee. Since you plan on continuing the Cigna brand, how will this impact growth opportunities for Cigna?**

We are confident in our ability to maintain compliance with the rules governing how insurers can operate under the Blue Cross Blue Shield brand. Further, we remain steadfast in our belief that the complementary nature of Anthem’s proposed acquisition of Cigna allows both brands to compete aggressively in the markets in which we would operate, while continuing to offer consumers greater choice, affordability, and access. It is important to note that, while companies operating under the Blue brand must meet certain thresholds in order to remain in compliance with license requirements, the Blue Cross and Blue Shield Association does not have approval authority over this transaction, how Anthem will use the Cigna brand, or how the combined company will compete in the marketplace. What makes this partnership so attractive to both companies is the opportunity to leverage each organization’s distinct strengths across different segments and geographies. It is our shared goal that the combined organization will continue to seek out and take advantage of these opportunities. Finally, if at any time we are determined to be out of compliance with the Blue Cross Blue Shield license thresholds, we are permitted a grace period to develop and implement an action plan to address any issues.

2. **The Blue Cross Blue Shield licensing agreement also reportedly includes a prohibition on licensees competing against any Blue Cross Blue Shield plans. How will this provision impact Cigna’s ability to compete against Blue Cross Blue Shield plans?**

That is incorrect. Anthem currently has a non-Blue Cross Blue Shield (BCBS) branded business that competes in service areas where Anthem does not have a BCBS license. The Anthem license, likewise, does not protect Anthem from competition from other licensees to the extent that they choose to compete with non-BCBS trademarked products. The license merely limits the use of the BCBS mark in competition with other BCBS marks within the same license area. This prevents confusion and disruption for consumers, while protecting the value of the licensed marks consistent with federal law, including trademark law. Thus, Anthem anticipates taking full advantage of the

Cigna brand to compete with other BCBS licensees in areas where Anthem is not a BCBS licensee. Anthem is also free to use the Cigna brand within Anthem's licensed BCBS service areas, as Anthem deems appropriate in its unilateral discretion.

That having been established, in my written testimony, I map out the distinct and complementary footprints – both geographic and by market segment – of Anthem and Cigna. Currently, Anthem competes with other Blue Cross Blue Shield licensees through our Amerigroup, CareMore, Simply Healthcare, and Better Health brands. Anthem intends to continue competing with other Blue plans under the Cigna brand. Whether one looks at the individual or small group segment (less than 50 employees), large employers (predominantly, self-insured and administrative services only contracts), Medicare Advantage, Medicaid Managed Care, or in the international market, there are few shared local markets between Anthem and Cigna. The differentiated reach of these companies only reinforces the robust level of local competition that characterizes the health insurance sector, ensuring that consumers will continue to benefit from the high degree of choice that enables them to make the health care decisions that best meet their needs.

3. Is your proposed merger motivated at all by, or in response to, consolidation among hospitals?

The movement towards consolidation in the health care sector, generally, is driven by a number of factors, including the shared recognition that the needs and demands of consumers are rapidly evolving. More specifically, consumers benefit when the options affecting their health care reflect both quality and cost. Health plans, like Anthem and Cigna, are able to draw from decades of experience, informed by the kind of specialized attention that comes from serving so many diverse communities across this country. Both companies value the role that they play in their members' lives, and both have made a deliberate investment in cultivating a spirit of collaboration with our provider partners. As the health care system continues to place greater emphasis on outcome-based care over the traditional, volume-based fee-for-service model, this partnership becomes increasingly important. However, market dynamics across the health care sector are shifting and we continue to see increased consolidation among hospital systems. In fact, a recent analysis discovered that more than 100 hospital consolidation deals were reported in 2012, up from the 50-60 per year seen between 2005 and 2007.¹ Further, it was predicted two years ago that 1,000 of the nation's roughly 5,000 hospitals could seek out mergers by the end of this decade.² Despite these dynamics, it would be an oversimplification to label the proposed merger between Anthem and Cigna as a reaction to what is being seen in the hospital sector, rather than what it truly is -- a desire to maximize the shared efficiencies and complementary capabilities of these companies to benefit consumers more quickly.

4. Certain parties have advanced criticisms of your proposed merger. For example, the AHA asserts that hospital mergers are fundamentally different than your proposed merger because your merger will have a more enduring impact. They additionally assert that even a modest price increase resulting from your proposed merger will lead to billions of dollars in additional

¹ Dafny, Leemore, "Hospital Industry Consolidation – Still More to Come?" *The New England Journal of Medicine*, Jan. 16, 2014 (<http://www.nejm.org/doi/full/10.1056/NEJMp1313948#t=article>).

² Creswell, Julie and Reed Abelson, "New Laws and Rising Costs Create a Surge of Supersizing Hospitals," *The New York Times*, Aug. 12, 2013 (<http://www.nytimes.com/2013/08/13/business/bigger-hospitals-may-lead-to-bigger-bills-for-patients.html>).

consumer cost. Please provide any additional information regarding these assertions that would be helpful to the Committee's evaluation of the related issues.

The costs that consumers experience when interacting with the health care system are a result of many variables. When evaluating rising premium costs, it is important to note that regulations, such as the medical loss ratio (MLR), cap the amount of profit that insurers may earn. For instance, under this provision, should Anthem exceed this cap, then that excess must be rebated to the customer. Against this backdrop, the fact that nearly 97 percent of premium increases are tied to increasing provider costs and prescription drug benefits underscores the disproportionate role that health care providers and pharmaceutical manufacturers have on consumers' premium expenses. To suggest that a combined Anthem-Cigna could simply raise premiums to the effect of "billions of dollars" therefore paints a misleading picture of the relationship between health insurer revenue, premiums, and the numerous drivers of health care costs in the U.S. The high degree of regulatory oversight and consumer protections that govern the provision of health insurance insulate the consumer from many of the variable costs that affect premiums. Further, consumers now have better access to information than ever before, which, in turn, has led to greater pricing transparency, better quality results, and improved affordability. Consumers have always known what they want and need from their care, and are now able to play a growing role in realizing those goals through a growing number of channels.

The AHA's assertion of the fundamental difference between hospital mergers and those seen in the insurance sector is not entirely without merit, however. Current independent analysis has established a correlation between price increases and hospital market consolidation.³ In contrast, mergers in the health insurance industry have the potential not only to protect consumers from these price increases through improved pricing transparency in negotiations and better management of health care costs, but also through enhanced administrative efficiency. Further, health plans play a pivotal role in using data to better understand and improve population health. The investment required to collect and analyze this data is not insignificant, though. The proposed merger will allow both companies – with distinct capabilities – to pool their resources in order to invest in, and develop, the technological infrastructure necessary to benefit providers and consumers through improved outcome-based benefit design and accelerated innovations that lead to reduced costs and enhanced care models.

- 5. Both AHA and AMA have presented studies that assert your merger would result in market concentration levels that would "raise significant competitive concerns." Please provide any additional information regarding these studies that would be helpful to the Committee's evaluation of the related issues.**

Health care is consumed and delivered locally. We maintain that when the U.S. Department of Justice (DOJ) reviews this transaction by market segment at a local level, they will agree with our analysis, and that the proposed merger will not result in the concentration levels suggested by the AHA. Further, it is worth pointing out that the calculations used by the AHA were not based on the type of economically-sound, consumer-centered evidence credited by antitrust economists or the DOJ. Their analysis failed to take into account the highly complementary footprints of the two organizations; in many cases, both companies do not even offer the same products to the same

³ Trish, E. E., and B.J. Herring. "How Do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums?" *Journal of Health Economics* 42, (July 2015): 104-114.

customers in the same geographies. Their cursory interpretation of the available market data is not only misleading, but also results in a misrepresentation of the minimal shared overlap between Anthem and Cigna. Similarly, the data used to assert the AMA's opinion is far too aggregated to accurately capture the distinct and complementary competitive focuses of Anthem and Cigna. Specifically, their analysis lumps all commercial market segments together, which only serves to present an inaccurate snapshot of competition in local health insurance marketplaces. While the AMA did allow that some of the product segments they used to build their argument may not be true competitors, they still chose to present the over-generalized data. Again, we have full confidence that the DOJ will conduct a thorough examination of the proposed merger, spending the appropriate amount of time and resources to carefully evaluate more accurate, reliable, and relevant data to determine the true impacts to markets and consumers.



**Response to Questions for the Record from Tom Nickels,
Executive Vice President, American Hospital Association (AHA)**



800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4955
(202) 638-1100 Phone
www.aha.org

November 9, 2015

The Honorable Bob Goodlatte
Chairman
Committee on the Judiciary
U.S. House of Representatives
2318 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Goodlatte:

I am writing in response to your request to address questions for the record related to my participation at the September 29, 2015, hearing before the Judiciary's Subcommittee on Regulatory Reform, Commercial and Antitrust Law, "Healthy Competition? The Proposed Health Insurance Mergers and the Consequent Impact on Competition."

Attached please find responses to questions from the subcommittee chairman.

If you have any questions about this information, please contact Megan Cundari, senior associate director for federal relations, at 202-626-2268 or mcundari@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

Attachment



Questions for the Record
Thomas P. Nickels, Executive Vice President, American Hospital Association
U.S. House Judiciary Committee
Subcommittee on Regulatory Reform, Commercial and Antitrust Law
“Healthy Competition? The Proposed Health Insurance Mergers and the Consequent
Impact on Competition.”
September 29, 2015

In response to Subcommittee Chairman Marino’s questions

1. In your written testimony, you argue that the barriers to entry for new insurance companies are significant. There have been reports of hospitals beginning to offer insurance products. Do you think that hospitals could serve as viable competitors to insurers, and are the barriers to entry lower for hospitals?

Answer:

The difficulty of successful entry into the commercial insurance business recently has been underscored by the collapse of nine insurance cooperatives. Entry on the scale needed to successfully compete with commercial insurers, made larger and even more powerful by the proposed transactions, would further discourage entry and make it exceedingly difficult for any new entrant to succeed. While a number of hospitals and health systems have begun to operate health plans, concentrated mainly on Medicare Advantage coverage, those plans cannot begin to replace the competition lost as a result of these potential commercial insurance transactions.

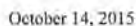
No hospital or health system plan would have access to resources to sustain and grow their nascent plans on anything like the same scale as Anthem or Aetna. Whatever initial advantage hospitals might have because they are a known and trusted entity in their communities could be overcome by an aggressive campaign to drive them out of the market by either of those insurers. Moreover, because they lack the scale of an Anthem or Aetna, it is unlikely that hospital plans could be fully price competitive in the foreseeable future.

2. In your written testimony, you state that your hospital members find it challenging to work with insurers on new value-based models. Can you provide additional detail regarding these challenges? How will the proposed merger affect those challenges?

Answer:

Commercial insurers, particularly those on the scale of an Anthem or Aetna, have no financial incentive to work with hospitals on value-based models in which savings or risk is shared. As stated in the AHA testimony, most commercial insurers have been content to let hospitals do the hard work of reducing the length and frequency of admissions, for example, and make other changes to delivering care that improve efficiency and decrease costs. That is because it is

insurers who reap the greatest financial reward from the hospitals' efforts. Without sufficient competition among the large commercial insurers, the incentive to work in partnership with hospitals will likely decrease even further. The proposed insurance company transactions would eliminate significant competition in hundreds and thousands of markets and would undoubtedly hamper hospitals' efforts to make important changes to the way in which care is delivered, and thereby ultimately harm consumers.



Dear Mr. Haislmaier,

The Committee on the Judiciary's Subcommittee on Regulatory Reform, Commercial and Antitrust Law held a hearing entitled "Healthy Competition? An Examination of the Proposed Health Insurance Mergers and the Consequent Impact on Competition" on Tuesday, September 29, 2015 in room 2141 of the Rayburn House Office Building. Thank you for your testimony.

Questions for the record have been submitted to the Subcommittee within five legislative days of the hearing. The questions addressed to you are attached. We would appreciate a full and complete response as it will be included in the official hearing record.

Please submit your written answers by Wednesday, November 25, 2015 to Andrea Lindsey at Andrea.Lindsey@mail.house.gov or 6240 O'Neill Federal Office Building, Washington, D.C. 20024. If you have any further questions or concerns, please contact Ms. Lindsey at (202) 226-7680.

Thank you again for your participation in the hearing.

Sincerely,

Bob Goodlatte
Chairman

Enclosure

Mr. Edmund Haislmaier
October 14, 2015
Page 2

Questions submitted for the Record from Subcommittee Chairman Marino

1. Some employers, particularly large employers, wish to shoulder the financial risk of insuring their employees and contract with insurance companies only to provide the administrative services of a health insurance plan. In your testimony, you cite the expansion of this "administrative only" service as potentially one of the motivations behind the Anthem-Cigna deal. How has the regulatory burden imposed by Obamacare impacted the number of employers opting to deploy this approach? Are we seeing more companies using this approach to avoid the regulatory burden? Should we have any concerns about operating companies attempting to manage the risks of health costs, particularly when they may not be well-suited to do so?

2. Do you think the Medicare Advantage market is attracting more robust competition relative to other insurance markets? If so, what is causing insurers to enter this particular market?

1. The trend of employers shifting from fully insured to self-insured plans has continued at the same modest rate as before enactment of the ACA. While there are provisions in the ACA that might accelerate that trend, such acceleration has so far not shown up in the enrollment data. One factor may be the Obama Administration delaying the implementation of the ACA employer mandate. Also, Congress recently eliminated the ACA provision that would have subjected employer plans with between 50 and 100 workers to the essential benefits coverage requirements and small group rating rules starting in 2016. Had Congress not acted, it could have been expected that more employers in that firm-size range might shift to self-insurance in the coming years to avoid the costs of those mandates.

The ability of smaller firms (those with less than 1,000 covered lives in their plans) to manage the risks associated with self-insuring need not be of particular concern. First, such firms are unlikely to take on those risks if they do not feel that they can manage them adequately. Second, there are a variety of tools available to help an employer manage the risks associated with self-insuring its health plan. In addition to contracting with vendors to perform administrative tasks, self-insured plans can transfer larger risks by purchasing “stop-loss” and “reinsurance” coverage and can manage smaller risks by contracting for services such as actuarial consulting, pharmacy benefit management, case management, etc.

2. Nationally, the markets for Medicare Advantage and individual health insurance are about the same size, but there are about 30 percent more insurers offering Medicare Advantage plans than insurers offering individual market coverage. The table below shows that the difference is due to the fact that, relative to the individual market, more of the insurers offering coverage in the Medicare Advantage market have small enrollment.

Number of Health Insurers by Size of Enrollment for Medicare Advantage and Individual Comprehensive Plans

	Medicare Advantage	Individual Comprehensive
Fewer than 1,000 enrollees.	123	35
1,000 or more enrollees.	173	172
Total	296	207

Typically, the smaller Medicare Advantage plans are sponsored by charitable organizations, local (county or city) governments, or provider systems. A number of them, particularly plans sponsored by local governments or charitable organizations, were initially created to handle Medicaid managed care contracts and then branched out to offer Medicare Advantage plans as well, especially to dual-eligible beneficiaries. In other cases, health systems created subsidiaries specifically to offer Medicare Advantage coverage—which is not surprising as Medicare is the largest payer for hospital services.

Generally, a provider sponsored plan offers coverage only in the geographic area served by its sponsoring health system. Plans sponsored by charitable organizations and local governments also tend to be locally focused, though a few of them are statewide. Prior to the ACA, few of these types of plans offered coverage in the individual or employer group markets, though in the last two years some have also started offering exchange coverage.