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

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

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-Tursman, "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 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/f2500/2501.pdf; *see also U.S. v. Aetna, Inc.,* No. 3-99 CV 1398-H, at 5-6 (Aug. 3, 1999) (revised competitive impact statement), *available at*: http://www.usdoj.gov/atr/case/s/f2600/2648.pdf.
[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/f213800/213815.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/spceches/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 IBC 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 No1:08 –cu-00322 (DDC2008); United States v. Humana, No. 12-cv-00464 (D.D.C. Mar. 27, 2012), *available at*: www.justice.gov/atr/cases/f281600/281618.pdf).

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

---

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

[31] *See U.S. v. United Health Group and Sierra Health Services Inc*., Civil No1:08 –cu-00322 (DDC2008) (the DOJ alleged that MA is a distinct market separate from the Medicare market and obtained a consent decree requiring the divestiture of United's MA business in the Las Vegas area as a precondition to obtaining merger approval); *see also* Gretchen A. Jacobson, Patricia Neuman, Anthony Damico, "At Least Half Of New Medicare Advantage Enrollees Had Switched From Traditional Medicare During 2006–11," 34 *Health Affairs* (Millwood) 48, 51 (Jan. 2015), *available at*: http://content.healthaffairs.org/content/34/1/48.full.pdf.

[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-H (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=417B9E62-CB8D-4FC7-905D-40F39B91E5E7&Statement_id=F6324A0C-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) ("Antitrust does not break up legally acquired monopolies or oligopolies.").

[41] *Id.*

[42] *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.

[43] *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.

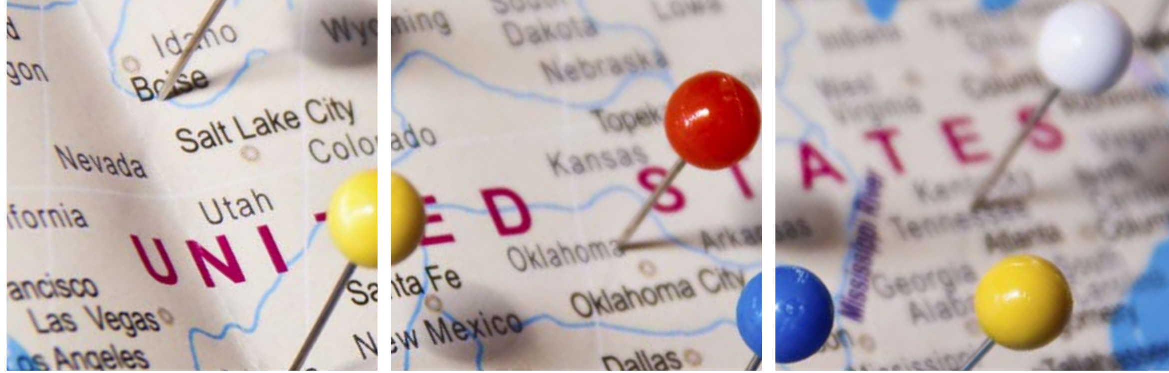
Furthermore, we are concerned that the narrowness of the self-referral exceptions with respect to physician compensation arrangements can make it exceedingly difficult to structure incentive payments tied to quality improvement criteria. In fact, the Government Accountability Office (GAO) has found that 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.

AMA
AMERICAN MEDICAL ASSOCIATION



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.

©2015 American Medical Association. All rights reserved.
15-0382:PDF:9/15:DF

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

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
Peoria, 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

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

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	2252	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

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

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
Abilene, TX	6437	6543	105
Wisconsin			
Appleton, WI	1961	2460	498
Green Bay, WI	1899	2203	304
Janesville, WI	1776	2056	280
Eau Claire, WI	2206	2384	178
Madison, WI	1711	1831	120

POS markets

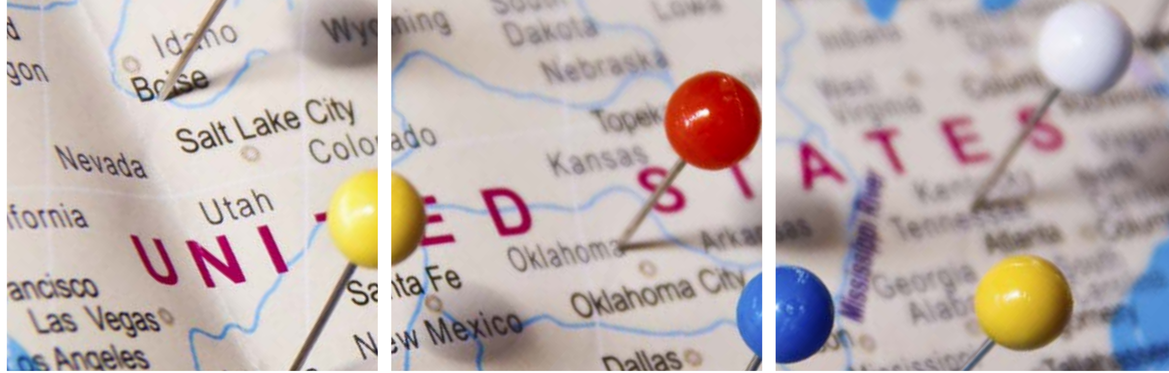
Table 12. MSAs where an Aetna-Humana merger will be presumed likely to enhance market power

MSA name	POS HHI	POS HHI post-merger	Change in POS HHI
Georgia			
Macon, GA	2615	2878	263

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

AMA
AMERICAN MEDICAL ASSOCIATION



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 market.

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, NV, 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, NV, 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, NV, NH, 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, NV, NH, 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.

©2015 American Medical Association. All rights reserved.
15-0382:PDF:9/15:DF

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
Oxnard-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

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

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
Lynchburg, 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
Massachusettes			
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	2747	526
Athens-Clarke County, GA	2890	3398	508

MSA name	PPO HHI	PPO HHI post-merger	Change in PPO HHI
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	3568	3943	375
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	4004	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

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

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
Massachusettes			
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

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