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

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[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/hus/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

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[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

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[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]

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[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/rzeckhau/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

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[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

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[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

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[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. Kessler, 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

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[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.
[53] *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/.
[54] *See Competition Among Medicare's Private Health Plans: Does it Really Exist?*, *supra* note 54.
[55] *Id*.
[56] *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

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[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-4FC7-905D-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-4FC7-905D-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

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[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.

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[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.

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[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 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.

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[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).