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September 21, 2015

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

Re: The Anthem/Cigna and Aetna/Humana Mergers

Dear Chairman Lee:

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

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

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

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

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

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

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

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

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

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

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

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

⁶ *States where health insurers are squeezing out competition*, AM. MED. ASSOC. (Sept. 8, 2015, 6:00 AM), <http://goo.gl/wUp3>.

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

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

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

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

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

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

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

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

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

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

¹³ See Thomas Greaney, *Examining Implications of Health Insurance Mergers*, HEALTH AFFS. (July 16, 2015), <http://goo.gl/ETT1DB>.

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

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

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

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

What is the Effect of Increased Monopsony Power?

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

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

What is the Impact on Competition in Health Insurance Exchanges?

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

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

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

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

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

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

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

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

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

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

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

The Potential Loss of Competition in Medicare Products

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

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

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

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

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

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

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

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

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

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

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

Can Remedies Cure the Loss of Competition?

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

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

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

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

³² *Id.* at 9.

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

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

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

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

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

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

Conclusion

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

Please do not hesitate to contact us with any questions.

Respectfully submitted,

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

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

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

³⁸ Dafny, *supra* note 10 at 1163.

³⁹ Guardado, *supra* note 10 at 21.

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

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Virginia Rural Health Association