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EXAMINING CONSOLIDATION IN THE HEALTH INSURANCE INDUSTRY AND ITS IMPACT ON CONSUMERS

HEARING

BEFORE THE

SUBCOMMITTEE ON ANTITRUST, COMPETITION POLICY AND CONSUMER RIGHTS

OF THE

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EXAMINING CONSOLIDATION IN THE HEALTH INSURANCE INDUSTRY AND ITS IMPACT ON CONSUMERS

TUESDAY, SEPTEMBER 22, 2015

UNITED STATE SENATE,
SUBCOMMITTEE ON ANTITRUST, COMPETITION POLICY, AND CONSUMER RIGHTS,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10 a.m., in Room 226, Dirksen Senate Office Building, Hon. Michael S. Lee, Chairman of the Subcommittee, presiding.

Present: Senators Lee [presiding], Tillis, Grassley, Hatch, Klobuchar, Coons, Franken, and Blumenthal.

OPENING STATEMENT OF HON. MICHAEL S. LEE, A U.S. SENATOR FROM THE STATE OF UTAH

Chairman LEE. Welcome to this hearing of the Subcommittee on Antitrust, Competition Policy, and Consumer Rights. Before we start, I would like to thank Ranking Member Klobuchar and her staff for their assistance in preparing for this hearing today. I would also like to thank the Chairman of the Full Committee, Senator Grassley, for his support of the hearing.

A few housekeeping matters that I would like to cover before we begin. After I, and then Senator Klobuchar, give some opening remarks about this hearing, we are going to hear from our panel of witnesses whom I will introduce in a few minutes, and then we will have 5-minute question rounds. I should also note that we are expecting an important vote on the floor this morning, and so I and other Members will likely need to step out briefly to participate. If necessary, we may briefly pause the hearing proceedings, although sometimes that does not become necessary, depending on the order in which people are asking questions.

We are here, as you know, to discuss the proposed mergers between four of the Nation's five largest health insurance companies. In early July of this year, Aetna announced that it had reached a deal to purchase rival Humana for $37 billion. A few weeks later, Anthem announced its own deal to purchase Cigna for $54 billion. The Department of Justice is currently reviewing both of these proposed transactions, and should the Department proceed without any objection or substantial modification to health insurance, industry's so-called Big Five will be reduced to the Big Three—UnitedHealthcare, Anthem, and Aetna—at the end of that process.

As with any merger between two major competitors, each of these acquisitions raises the question of whether the merging businesses' product offerings overlap in any geographic market. The relevant antitrust inquiry is, of course, whether the combination will lead to a market concentration that may substantially lessen competition.

These transactions and their concurrent review also raise questions about the broader issue of consolidation in our Nation's health insurance industry. It is my hope that our discussions today will assist the public and assist lawmakers in understanding what is causing the trend toward consolidation, as well as how it may affect consumers. As we have seen since the passage of the Patient Protection and Affordable Care Act, sudden and drastic changes to the health care markets can lead to financial uncertainty and increased strain on consumers and on their families.

While vibrant competition in every industry is important to our economy, consumers and policymakers pay special attention whenever health care is involved, as it is here. Health care markets are distinguished from those for other goods and services by their complexity, financial incentives, and inelastic demand. Health-related goods and services reach consumers through a byzantine labyrinth of manufacturers, wholesalers, pharmacy benefit managers, insurance companies and other third-party payers, providers, pharmacies, State and Federal Government agencies, and sometimes employers. In many instances, those prescribing care, those receiving care, and those paying for care are all different entities. But despite these complexities and despite the often high costs for health care, everyone will at some point require it. Of course, health care also touches on some of the most sensitive and life-changing decisions made by consumers, decisions that have a lasting impact on their personal as well as on their economic well-being.

That brings us to the present transactions. The first to be announced was that between Aetna and Humana, the third and fifth largest national health insurers, respectively. Aetna serves an estimated 46 million people globally, offering a variety of health insurance products, including dental, vision, Medicaid, Medicare Supplemental, Medicare Advantage, and concentrations—commercial policies. Aetna's primary focus is in commercial health insurance, particularly national accounts and large multi-site self-insured employers. Humana has over 14 million members and product offerings focusing on Medicare, with at least one Medicare product in every State in the Union. Humana is the second largest Medicare Advantage provider just behind UnitedHealthcare.

The second transaction, between Anthem and Cigna, proposes to combine the second and fourth largest national health insurers, respectively. Anthem is the largest member of the Blue Cross and Blue Shield Association, operating under that brand in 14 States. Anthem has over 38 million health insurance customers spread across its small-group, Medicare, Medicaid, individual, and commercial products. Cigna has over 14 million covered lives and focuses on commercial health insurance offerings.

Each of these deals is in and of itself incredibly complex and raises its own set of unique concerns. Industry observers have

noted that the primary area of overlap between Aetna and Humana is in their Medicare Advantage businesses. The American Hospital Association identified nearly a thousand counties in which the post-acquisition concentration level in the market for Medicare Advantage raises strong competitive concerns. Others, however, question both the accuracy of the data cited and the interpretation of that data. While some are concerned the deal will lead to higher prices and fewer choices for consumers, the companies have identified $1.25 billion in potential efficiencies. The Anthem-Cigna merger is viewed to involve overlap primarily in the commercial health insurance market. The American Hospital Association claims the deal may result in concerning concentration levels for commercial health insurance products in up to 807 metropolitan areas. The insurance companies again strongly dispute these numbers, arguing that if they fail to separate out different insurance products that—that those conclusions fail to separate out different insurance products that are in different product markets. Anthem and Cigna believe they are joining complementary businesses in a way that will allow them to lower costs and improve quality for consumers.

Anthem's acquisition of Cigna also raises questions regarding how Cigna will be integrated into the Blue Cross Blue Shield system. Anthem's membership agreement in the association places limits on how much of their business may be conducted outside the Blue Cross and Blue Shield brands. It is possible that Cigna's ability to compete post-acquisition may be constrained by Anthem's membership in the Blue Cross and Blue Shield Association. For its part, Anthem believes that the addition of Cigna's members will not cause them to run into any limits imposed by the association's membership agreement.

In addition, there is the question of how these mergers may effect nascent forms of competition in the health insurance industry, specifically the trend toward value-based reimbursement and outcome-based treatment models. These alternative approaches to health care seek to improve care and lower costs by focusing on patient outcomes and overall health, particularly through preventative care, rather than simply paying for services on a fee-basis. As the marketplace evolves in response to consumer demand and Government policies, it will be important to ensure that consumers are benefiting from vigorous competition and wide choice rather than being locked into the offerings of just a few dominant companies within the industry.

Finally, we cannot ignore the far-reaching effect that the Affordable Care Act and the effect it has had on the health insurance marketplace in America. While I would like to emphasize that this is not a hearing on Obamacare, a discussion of its role in current industry consolidation is unavoidable given the way the Act has transformed the structure and the provision of health insurance in America. It is important for us to ask how it may be affecting competition in these markets.

We can see, these issues that are raised by these proposed transactions and the complexities of the health care space provide ample topics for our discussion today. While the final determination regarding the competitive impact of the deals will, of course, be made by the Department of Justice, I believe we can make valuable con-

tributions to the conversation today by closely examining any concerns they raise and by looking at what other forces or market realities may be driving consolidation in the health insurance industry.

Particularly at a time when the debate over national health care policy continues with great fervor, and the health care marketplace is rapidly evolving to meet the demands of the 21st century, it is essential that lawmakers and regulators in Washington pay close attention to the impact of our actions on competition and the free market. I hope that we can make strides to that end today, and I look forward to hearing and engaging with the testimony of our highly qualified panel of witnesses.

Senator Klobuchar.

OPENING STATEMENT OF HON. AMY KLOBUCHAR, A U.S. SENATOR FROM THE STATE OF MINNESOTA

Senator KLOBUCHAR. Thank you very much, Chairman Lee. Thank you for holding this hearing. Thank you to all of our witnesses. This is an important hearing to examine the consolidation in the health insurance industry, and I want to welcome all of our witnesses. I think we all know that the cost and the quality of health insurance affects all of us.

As a Nation, we value competition. The Supreme Court has called the Sherman Act the "Magna Carta of free enterprise." As a Nation, we have developed a broad consensus that competition leads to lower prices and higher quality. By protecting competition, the antitrust law delivers those benefits to American consumers. This is true across industries.

For a long time, however, people saw the health care industry differently. In the 1970s, some worried that competition would lead to a medical arms race where providers would unnecessarily duplicate services and increase costs. More recently, we have come to understand that competition at all levels of health care delivery systems benefits consumers.

Consequently, the proposed merger of four of the five largest health insurance companies could change the industry, and its impact on consumers must be carefully scrutinized. Together these four insurers cover, as the Chair has noted, over 90 million people, almost 3 out of 10 Americans. We spent over $960 million on health insurance in 2013, and cost-effective health insurance, as we all know, is critical for the access that Americans need for quality health care.

There are some who are convinced that if this merger is approved, consumers will pay more for insurance, receive fewer benefits, and have less time with their doctors or other health care professionals. Others with equal fervor believe that competition will remain vigorous because many alternatives will continue to exist in the market and that each combination will help improve health care.

For me, I think we need to explore two key questions: first, the effect of these mergers on consumers; and, second, the impact on the integrity of our health care system.

I want to make sure that these deals do not harm consumers by increasing premiums or reducing benefits. Also, we need to con-

sider whether these mergers will enable insurers to gain undue advantage in dealing with health providers that could reduce the quality of care.

Equally important, we want to consider whether these transactions could enhance competition. Here the questions are broader. The health care industry is undergoing a significant transition as we move toward more coordinated care and rewarding outcomes instead of paying for procedures. Will these mergers support or impede the goal of coordinated, outcome-based care?

The Antitrust Division of the Department of Justice has significant experience reviewing health insurance mergers. They have typically analyzed these deals by looking at how the merger would affect individuals, small employers, large employers, and Medicare Advantage plans. They have generally analyzed health insurance markets as local. An insurer must offer access to providers close to where the consumer works or lives to be viable. Typically, the Antitrust Division has found entry to be difficult, citing the cost of entry into a geographic area, the time it would take, and the barriers posed by the reputation of the merged entity and the products that it provides.

At the same time, significant changes are occurring. We now have public insurance exchanges that empower individuals. Some companies have adopted that idea and provide private exchanges for their retirees or employees where the consumer chooses from a menu of potential plans. Certain provider groups have begun offering their own insurance plans. Typically, we weigh the potential for harm from a merger against likely benefits. In other words, will the merger lower costs or improve quality in a way that is unlikely to occur without the merger? Equally important, will these benefits flow to consumers?

Mr. Chairman, I will be interested in hearing from our panel on how they approach these issues. I am personally very interested in another issue related to health care, and that is, prescription drug prices, and I hope it is something we will also consider in the future. Senator Grassley and I just introduced or reintroduced our pay-for-delay bill with regard to generic and pharmaceutical deals that we think harm consumers. Second, I have a bill with Senator McCain on allowing reimportation of drugs from Canada, and then a bill that allows for negotiation under Medicaid Part D. While we are focused today on the health insurance issues, I think we all know there are other issues related to costs as well in this industry that must be examined as we are seeing some greatly escalating costs in the pharmaceutical market especially.

Thank you, Mr. Chairman.

Chairman LEE. Thank you. I am now going to introduce each of our witnesses before we swear them in and hear from each of them.

Mark Bertolini is chairman and CEO of Aetna. He joined Aetna in 2003, and has served in various capacities prior to assuming the role of CEO in 2010, and as chairman in 2011. Mr. Bertolini holds an undergraduate degree in business administration and finance from Wayne State University and an MBA in finance from Cornell.

Joseph Swedish is the president and CEO of Anthem. He joined Anthem in March 2013. Mr. Swedish's more than 40 years of health care experience include 25 years as CEO for several major

hospital and health care systems. Mr. Swedish received his bachelor's degree from the University of North Carolina at Charlotte and his master's degree in health administration from Duke University.

Dr. Paul Ginsburg is the Norman Topping Chair in Medicine and Public Policy at the University of Southern California, where he is affiliated with the Schaeffer Center for Health Policy and Economics. Continuing to be based in the Washington, DC area, he teaches graduate health administration courses and conducts health policy research. Until the end of 2013, he was president of the Center for Studying Health System Change, which he founded in 1995. Dr. Ginsburg served as the founding executive director of the Physician Payment Review Commission, now the Medicare Payment Advisory Commission, and as Deputy Assistant Director at the Congressional Budget Office. He earned his doctorate in economics from Harvard University.

Leemore Dafny is professor of strategy, director of health enterprise management, and the Herman Smith Research Professor in Hospital and Health Services at the Kellogg School of Management. Her research examines competitive interactions among payers and providers of health care services and the intersection of industry and public policy. Dr. Dafny is a graduate of Harvard College and earned a Ph.D. in economics from MIT. She is a research associate at the National Bureau of Economic Research, editor of an international journal of health economics and management, and a board member of the American Society of Health Economists and the Health Care Cost Institute. In 2012 to 2013, Dr. Dafny served as Deputy Director for Health Care and Antitrust in the Bureau of Economics at the Federal Trade Commission in Washington. She is a current member of the panel of health advisers for the Congressional Budget Office.

Rick Pollack became president and CEO of the American Hospital Association on September 1, 2015, after serving AHA in various roles over the last 33 years. Rick holds a bachelor's degree in political science and communications from the State University of New York at Cortland. He also earned a master's degree in public administration from American University.

George Slover is senior policy counsel in the Washington office of Consumers Union, the public policy and advisory division of Consumer Reports. He previously worked at the Justice Department's Antitrust Division and at the House Judiciary Committee where he was lead antitrust counsel and later chief legislative counsel and parliamentarian. He is on the advisory board of the American Antitrust Institute, is an elected member of the American Law Institute, and currently serves as co-chair of the DC Bar's Antitrust and Consumer Law Section. He holds a J.D. from the University of Texas Law School and a master of public affairs from the LBJ School.

I would ask each of our witnesses to stand and be sworn. Do you affirm that the testimony you are about to give before the Committee will be the truth, the whole truth, and nothing but the truth?

Mr. BERTOLINI. I do.

Mr. SWEDISH. I do.

Dr. GINSBURG. I do.
Dr. DAFNY. I do.
Mr. POLLACK. I do.
Mr. SLOVER. I do.
[Witnesses are sworn in.]

Chairman LEE. Okay. We will now hear brief remarks from each of our witnesses. We will start with Mr. Bertolini and head down this side until we get through Mr. Slover. Mr. Bertolini.

STATEMENT OF MARK T. BERTOLINI, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, AETNA, INC., HARTFORD, CONNECTICUT

Mr. BERTOLINI. Good morning, Chairman Lee, Ranking Member Klobuchar, and Members of the Subcommittee. My name is Mark Bertolini. I am the 14th chairman and CEO of Aetna, which was founded in 1853 in Hartford, Connecticut. I thank you for having me here today to discuss our acquisition of Humana.

We are at a time of unprecedented change in our country as we look at how health care is rendered, how much it costs, and what the outcomes are around health care. It is our view that we are—it is time for a change. Payment reform is on the forefront, expansion of coverage, every American should have health care coverage. Aetna was one of the first companies in 2005 to call for guaranteed issue and an individual mandate for health care coverage.

What I would like to talk about today is why the Humana acquisition is important to furthering our evolution as a health care company and as a health care system in the United States, focused on providing the highest quality available, the best and most affordable coverage available for all Americans.

After the acquisition, Aetna will have a product portfolio balanced more evenly between commercial and Government products, such as Medicare and Medicaid. Today the market competes on price and choice of doctor, and this will not change. To win in the market, we believe consumers should also be able to pick products that are focused on improving the health of the member.

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

I realize the Committee's purview is about competition and consumer choice, and while you are no doubt concerned about health, let me address the competition and choice issues directly.

First, it is important to point out that of the 54 million beneficiaries in Medicare today, 37 million, or 68 percent, receive their care through Medicare fee-for-service, while the remaining 17 million, or one-third, get their care through Medicare Advantage, or MA, the private Medicare option delivered through health plans.

Post-acquisition, we believe that robust choice and competition will remain in the Medicare market. There are 143 health care companies offering MA plans, with new entrants coming into MA every year. Twenty-eight new health plans have joined in the last 3 years, of which 15 are owned by providers. All health care is

local, and today in over 3,200 counties across the country 3,100 offer an MA coverage.

Beneficiaries have an average of 18 MA private plans to choose from, and even in nonmetro or more rural areas, there is an average of 10 plan choices to choose from.

After the transaction, only 8 percent of Medicare beneficiaries will receive their health benefits from Humana or Aetna, meaning that 92 percent of all beneficiaries will receive their health plan benefits from either Medicare fee-for-service or other MA plans.

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

After the transaction, other companies will have 87 percent of commercial enrollment, and on public exchanges Aetna and Humana together overlap in only 8 States. In those States there are on average 10 other insurance companies as competitors. We believe that there will be no material change to the competitiveness of the commercial insurance market as a result of our transaction.

Concerning the price of our products, premium prices are not determined in the abstract. Instead, they are driven by the underlying cost of care such as hospital, doctor, and prescription drug costs, which make up nearly 85 percent of premium prices. Given that this transaction is largely about MA and pricing, protection is even more assured by the Government establishing MA rates based on the cost of health care in each county. Insurance companies offering MA plans must bid against a Government benchmark set in each county and are incentivized to be competitive. Hence, many companies offer zero premium plans to consumers, zero dollar premium plans.

In fact, MA premiums have decreased by 6 percent since 2010. MA enjoys overwhelming support from its members currently with a 90-percent satisfaction rating, making it one of the most popular Government programs.

Sharing a common culture. Mergers and acquisitions are not just about efficiencies and business goals. Both Aetna and Humana share a common culture and, in fact, when Humana CEO Bruce Broussard and I met, our discussion was first focused on the compatibility of our cultures. Culture trumps strategy. Both cultures are focused on improving health, not just selling products.

Some of you may be familiar with my own journey with the health care system, and as difficult as that journey was for me and my son, it strengthened my resolve to make the health care market more competitive and improving the basis of underlying health.

We are focused on building a consumer-centric health system, and if we make that happen in Medicare, one of the biggest components of our health care system today, we can make it happen across all health insurance segments.

I know when acquisitions occur there is a great concern for jobs. As someone who started my career as a blue-collar worker, I understand the challenges of living paycheck to paycheck. It is why I have led an effort in corporate America to improve the wages and

benefits of our employees. Aetna raised its minimum wage in April to $16 an hour and is subsidizing health care benefits for employees whose household income is less than 300 percent of the Federal poverty level, impacting as much as 7,000 of our employees.

As part of this transaction, these benefits will be extended to 10,000 Humana employees currently earning less than $16 an hour. There will be some dislocation of jobs initially, but our expectation is to increase our employment by continuing to provide high-quality and affordable products to the market.

In closing, Aetna's acquisition of Humana is about creating positive change in the health care market. It is about being part of an effort to build a modern health care system built around the consumer. It is about challenging the competition to compete not just on old but important dimensions, but improving the number of healthy days that consumers can enjoy each year to live the most productive lives possible. We believe our acquisition will improve competition in the Medicare marketplace by providing affordable and higher-quality products.

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

[The prepared statement of Mr. Bertolini appears as a submission for the record.]

Chairman LEE. Mr. Swedish.

STATEMENT OF JOSEPH SWEDISH, PRESIDENT AND CHIEF EXECUTIVE OFFICER, ANTHEM, INC., INDIANAPOLIS, INDIANA

Mr. SWEDISH. Thank you, Chairman Lee, Ranking Member Klobuchar, and Members of the Subcommittee. I am Joseph Swedish, president and chief executive officer of Anthem, and it is my honor to appear before you today.

The work of this Committee and the dialog we engage in will help shape the future of health care in America, and I appreciate the opportunity to contribute Anthem's perspectives and experience.

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

My written testimony details the complementary nature of Anthem's and Cigna's businesses, the market dynamics impacting this transaction, and our commitment to working cooperatively throughout the review process. I would like to focus my remarks today on the most important beneficiaries of this proposed transaction: the consumers.

Health care is undergoing an unprecedented transformation, and while affordability, access, and quality are goals unanimously shared by our health care system, they are not universally enjoyed by consumers. Together, Anthem and Cigna will have the resources and capabilities to offer a broader portfolio of products and serv-

ices, to keep health benefits more affordable, and to promote accountable, higher-quality health care for consumers. Simply put, the combination of Anthem and Cigna will allow us to provide better health insurance to more people.

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

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

Much of the attention around this acquisition focuses on competition, and this is certainly an essential part of the dialog. As a baseline, it is important to recognize that health care is fundamentally local—locally based, locally delivered, and locally consumed.

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

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

Throughout my 40-year career in health care, I have worked diligently to instill a culture of innovation and collaboration across many organizations that I have led, and the combined company will be no exception. Separately, Anthem and Cigna have made meaningful progress in improving affordability, access, and quality for consumers, and together we can and will do much more.

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

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

[The prepared statement of Mr. Swedish appears as a submission for the record.]

Chairman LEE. Dr. Ginsburg.

STATEMENT OF PAUL B. GINSBURG, PH.D., NORMAN TOPPING CHAIR IN MEDICINE AND PUBLIC POLICY, UNIVERSITY OF SOUTHERN CALIFORNIA, WASHINGTON, DC

Dr. GINSBURG. Chairman Lee, Ranking Member Klobuchar, and Members of the Subcommittee, I am very grateful for this opportunity to testify on this issue.

For the past 20 years, I have studied changes in the financing and delivery of health care and their impact on people. My goal today is to point out how mergers of large national insurers fit into the ongoing and future changes in health care financing and delivery.

Mergers among health insurers are inherently difficult to analyze. Most insurers, especially large ones, operate in numerous market segments, most of them distinct by geographic area. As intermediaries between the providers of care and those who are insured, they operate as both buyers and sellers. We may believe that a merger will lower prices paid to providers, but then need to analyze whether these will be passed on to those who purchase insurance.

The Department of Justice will conduct a detailed analysis of the possible effects of these mergers, and if there is approval, there may be requirements for divestitures. Without being privy to this analysis, I do not have a position concerning whether or not these mergers should be approved.

Market concentration is only one dimension that affects how competitive health care markets are, and Federal policy and other factors behind market entry can have profound effects on competitiveness. For example, if Congress created a competitive bidding process for Medicare Advantage plans, that market would be more competitive. The Affordable Care Act appears to have made the market for individual insurance far more competitive than it was before, and significant numbers of large health systems are entering insurance markets with their own plans that favor their own providers.

Notwithstanding the focus on market consolidation, I see some important potential upsides of the mergers we are discussing today. For one, Wall Street analysts believe that these mergers will lead to substantial reductions in administrative costs. The mergers are likely to hasten the movement to alternative payment models. Having more lives in a market makes a health plan a more attractive partner to providers to create these models.

Mergers allow plans to invest more in data and analytics to support providers better in these models. It also addresses the vulnerability that many providers feel about the transition to alternative models, which they often describe as having "one foot in the boat and the other foot on the dock". If they are passed on to consumers, obtaining lower prices from providers can be an upside to mergers. International comparisons of spending have long shown that higher provider prices account for an important part of higher health care spending in the United States.

Staff asked me to comment on the role that the Affordable Care Act has played in these insurance mergers, and I would begin by saying that the most controversial parts of the Affordable Care

Act—subsidies to private insurance and Medicaid expansion—likely are not major factors. Other parts, though, are more important, though many of these impacts should be seen in a positive light.

Medicare's vast piloting of alternative payment models is expanding the opportunity for private insurers to pursue these models as well, and cuts in hospital rates and the Cadillac tax may also be pushing this forward.

Medical loss ratio minimums are motivating reductions in administrative costs, which they were intended to do. And, finally, cuts in Medicare Advantage rates are increasing the pressure to make these plans more efficient.

I would be pleased to answer the Subcommittee's questions. Thank you.

[The prepared statement of Dr. Ginsburg appears as a submission for the record.]

Chairman LEE. Dr. Dafny.

STATEMENT OF LEEMORE S. DAFNY, PH.D., HERMAN SMITH RESEARCH PROFESSOR OF HOSPITAL AND HEALTH SERVICES, KELLOGG SCHOOL OF MANAGEMENT, NORTHWESTERN UNIVERSITY, EVANSTON, ILLINOIS

Dr. DAFNY. Thank you, Chairman Lee, Ranking Member Klobuchar, and Members of the Subcommittee for the opportunity to testify today on consolidation in the health insurance industry. I am a professor of strategy at the Kellogg School of Management where I also direct the Health Enterprise Management Program. I study competition in health care markets using data-driven economic analysis. I previously served as Deputy Director for Health Care and Antitrust in the Bureau of Economics at the Federal Trade Commission.

We are here today because Americans are concerned about the steep price of buying health insurance. Even as their premiums rise, they face increases in deductibles and co-payments. More than a decade ago, I began studying whether a lack of competition in the health insurance industry contributes to higher premiums. It does. We are paying a premium on our premiums because of limited competition. My most conservative estimate would place that extra premium at over $200 per person per year.

The question before us today is whether more consolidation is likely to benefit consumers in the future. To inform that discussion, I will describe what we know about consolidation in the past, why those conclusions remain relevant, and what might increase the likelihood that any future consolidation benefits the public.

First, what do we know? We know less than we should because public data are limited and cover only subsets of the industry. We know that the market for full medical insurance would be deemed highly concentrated in 38 States according to the thresholds defined by the Federal Trade Commission and the Department of Justice.

We know that 37 percent of Medicare beneficiaries live in counties where the Medicare Advantage market would also be deemed highly concentrated. Concentration in both of these industries has been rising in recent years.

The best available evidence on the impact of consolidation comes from what are known as event studies or merger retrospectives. My colleagues and I studied such an event—the 1999 merger between Aetna and Prudential. We examined the impact of the merger on premiums for large employers in 139 different geographic markets. Where Aetna and Prudential had the greatest overlap we found the largest reductions in health care employment and wages. We would have expected premiums to go down in these areas, but the opposite was true. Put simply, the merger led to reduced payments to providers, but the cost savings were not passed through.

It was not just Aetna and Prudential raising premiums. Their rivals raised premiums as well, and premiums did not recede, even after Aetna lost significant market share.

There was a bright spot, though, and that was in Texas where the Department of Justice required the merging parties to divest plans. There were no significant merger effects on providers or premiums in those markets.

Other researchers have also found that payer mergers lead to higher premiums, and there is no evidence that mergers have led to improve quality or to more innovation. That was then, some might say, and this is now. Insurers now face minimum medical loss ratio regulations and must spend at least 80 or 85 cents out of every dollar collected, net of taxes and fees, on medical claims and on quality improvement. Despite what you may hear, this regulation does not provide a substitute for competition.

First, it does not pertain to self-insured plans, which include more than half of the people in privately insured plans.

Second, in a truly competitive market, insurers also compete on nonfinancial dimensions, such as the quality of provider networks and their chronic disease management programs.

Third, what if the regulation is eventually repealed?

Certain mergers may yield efficiencies from economies of scale or from other sources, and that is not different today than it was in years past. Consumers are likelier to benefit from these efficiencies where there is a market imperative to pass the savings along.

In light of the consolidation that has already taken place, however, the market imperative is now weaker, and consolidation could jeopardize it further.

In sum, evidence from the past should not be discounted when evaluating proposed consolidations. I would caution that consolidation that occurs now is unlikely to be undone if it later proves anticompetitive. History also suggests that vigorous competition by new entrants is unlikely to arise and to offset such effects.

The Department of Justice will evaluate the mergers we have just heard about and determine if the deals violate antitrust laws and follow through accordingly. Whether mergers are in the public interest and whether they violate antitrust law are two different issues. To serve the public best, I advise that you not only ask tough questions of the health insurance industry but demand greater transparency and consider regulations to require it. With comprehensive data in hand, policymakers and regulators will be able to monitor market developments and to intervene if necessary based on better and more timely information. Researchers such as

myself will be able to provide stronger guidance regarding the likely effects of consolidation.

Thank you.

[The prepared statement of Dr. Dafny appears as a submission for the record.]

Chairman LEE. Mr. Pollack.

STATEMENT OF RICHARD POLLACK, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. POLLACK. Thank you. Chairman Lee, Ranking Member Klobuchar, and distinguished Members of the Subcommittee, on behalf of the Nation's hospitals, thank you for inviting me to be here today.

Anthem's proposed acquisition of Cigna and Aetna's proposed acquisition of Humana would eliminate two of the largest national health insurance companies, leaving just 3 dominant providers of health insurance. This unprecedented consolidation should be of extreme concern for millions of health care consumers, as well as doctors, hospitals, and others who are working to improve quality and efficiency while making care more affordable to patients.

For consumers, these deals could make health care more expensive and less accessible. This applies to insurance purchased in the commercial market as well as Medicare Advantage plans.

We are also concerned about the negative consequences for consumers and health care providers that could result from further entrenching the power of the Blue Cross and Blue Shield system whose plans currently dominate the market in nearly every State.

Another likely casualty of these deals is derailing the momentum hospitals have established to improve the Nation's health care delivery system in pursuit of better—better health, better health care, and lower cost.

Despite claims that commercial insurers are fostering innovation, they continue to benefit financially from both squeezing provider payments and riding the wave of hospital efforts that are resulting in more efficient and higher-quality care. In fact, numerous studies have shown that the quality of care hospitals provide is increasing, and at the same time, hospital price growth is at historically low levels—less than 1 percent in 2015 and 1.3 percent last year. There is no reason to believe that allowing these insurers to become even larger and more immune from competitive forces would change their incentive to sit mostly on the sidelines and reap the considerable financial rewards of providers' innovation.

I would like to focus on some of our specific concerns with each of the proposed deals. If these proposed deals were to close, it would mean that the three largest national health insurance companies who last year had more than $345 billion in revenue would cover more than 131 million lives. That is about 2 out of every 5, or 40 percent, of Americans who have health insurance.

Anthem's acquisition of Cigna threatens to reduce competition for health insurance in at least 817 markets across the Nation that serve 45 million consumers. Because the two companies generate more than $100 million in revenue, even a slight increase would cost consumers billions of dollars in health care costs.

Meanwhile, if Aetna is permitted to acquire Humana, Medicare Advantage plans in more than 1,000 markets that serve more than 2.7 million seniors would become even more concentrated. That threatens the financial protection the Medicare Advantage program provides for enrollees and would likely result in higher out-of-pocket costs and fewer benefits. The deal would not only eliminate the current competition between Aetna and Humana in the Medicare Advantage market, it would also eliminate the possibility of future competition between them. This is particularly concerning because, even now, there is almost no competition in Medicare Advantage markets. An August Commonwealth Fund study found that 97 percent of the Medicare Advantage markets in the United States are "highly concentrated."

In conclusion, we are very concerned that both deals could result in fewer choices for consumers, narrower networks of providers in what few choices remain, and higher premiums and out-of-pocket costs. That is why both of these acquisitions merit the closest scrutiny from the Department of Justice's Antitrust Division and Congress.

Some have compared the insurance deals to those in the telecommunications arena because of their size and potential to contort the market and harm consumers. The Department of Justice was ready to challenge the telecommunications deals, and it should be ready to challenge these insurance deals if it finds that these transactions threaten the vitality of our health care system and the health and welfare of consumers across the Nation.

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

Thank you, Mr. Chairman.

[The prepared statement of Mr. Pollack appears as a submission for the record.]

Chairman LEE. Mr. Slover.

STATEMENT OF GEORGE SLOVER, SENIOR POLICY COUNSEL, CONSUMER UNION, WASHINGTON, DC

Mr. SLOVER. Thank you, Chairman Lee, Ranking Member Klobuchar, and Members of the Subcommittee.

Consumers want enough competition to give us meaningful choice—easy to compare, and responsive to what is important to us. Choice gives us leverage so sellers strive to give us lower prices and better quality.

From our founding 80 years ago, Consumers Union has worked to make quality health care available and affordable for all. This marketplace is complex in how it operates and motivates. Regulation helps ensure safety, control costs, and make better health care available. You cannot run the system on competition alone and let the free market go where it will. Pre-existing conditions is a prime example.

Competition adds an incentive to want to improve service while holding down costs. Some collaboration and integration can be good for the overall functioning of the system, but too much concentration among hospitals or doctors or insurers can undermine the system and harm consumers. Dominant players start dictating to oth-

ers, closing off choices consumers want, increasing the prices we pay, and impairing the quality of what we receive.

Health insurers play a key role in controlling costs. They gave us the disallowed amount—the difference between what the provider wants to charge and what it is willing to accept. A dominant insurer could push doctors and hospitals to go beyond trimming costs and begin to degrade care below what consumers value and need. We are concerned that these two mergers could create too much concentration in too many markets with too much harm.

There are submarkets in each local area, different kinds of insurance coverage where competition will not cross over. Seniors are not giving up Medicare Advantage to switch to the State exchange. We need to look at current competition, but also where competition could be. These four insurers are active throughout the country, and in prime position to expand into new markets.

We need to be skeptical of relying on new entry by others. If these four giants have decided that expanding on their own is not worth the trouble, how can we count on expansion by other smaller, even nonexistent insurers?

Same with relying on divestitures. For one thing, it looks like too many markets are affected here. Second, divestitures do not always work. Supposedly, this other company is ready to jump in with the same capability and commitment to compete over the long haul. That is always a roll of the dice. If this new company is really so capable and committed, why wasn't it there already?

It is risky to allow mergers right up to the brink of harm. There is no margin for error or change. What if a key player later decides to close shop? The law cannot force a company to stay in business.

Some say giving insurers more market power will offset market power of hospitals and doctor groups. The answer is not to give insurers their own market power and then hope they will use it to protect us. That is the sumo wrestler theory: adding market power at one place in the supply chain to stand up to it somewhere else. The result is more market power. The two sumo wrestlers end up shaking hands, finding a path to enrich them both, and then everyone else—consumers and smaller hospitals, local clinics, and medical practices—gets tossed around and flattened.

We want providers motivated to lower rates without cutting corners on quality of care, responding to competition versus knuckling under to a market dictator. True, an insurer of a certain size can get providers to willingly accept lower rates by offering access to enough patients. Where these four giants are not already well past that size, you would think they could get there by expanding on their own. Being of a size to offer that advantage to attract providers and consumers is different from having the power to make them an offer they cannot refuse.

Competition keeps the business interests of health insurers better aligned with the interests of consumers.

The Justice Department's investigations are just getting under way. We do not prejudge their outcome. But we want them to be very thorough and for the Department to act aggressively to protect us.

Thank you.

[The prepared statement of Mr. Slover appears as a submission for the record.]

Chairman LEE. Thank you, Mr. Slover.

Okay. Our first round of questions will be by Chairman Grassley, who is with us, but he has to leave in a minute, so we will hear first from Chairman Grassley. He will have 5 minutes, then 5 minutes to Senator Klobuchar, then I will take 5 minutes, and then Senators Coons, Tillis, Franken, Hatch, Blumenthal will proceed in that order.

Chairman Grassley.

Chairman GRASSLEY. Thank you, Mr. Chairman, for your courtesy, and I would put a statement in the record that I would have given if I had been here on time.

[The prepared statement of Chairman Grassley appears as a submission for the record.]

Chairman GRASSLEY. Mr. Bertolini and Mr. Swedish, there has been a good deal of discussion about efficiencies. Both of you expect—Mr. Bertolini, I believe you anticipate saving approximately $1.25 billion annually by 2018. That stands to reason. If there were not cost savings, obviously, I do not suppose you would be pursuing these mergers. How will these mergers impact the lives of ordinary consumers in Iowa? Two or three years after these transactions, will Iowans see a difference in their premiums or deductibles? Will their experiences be different in terms of service provided? Kind of summing it up, at the end of the day, how would these mergers make things better for consumers in my State of Iowa?

Mr. BERTOLINI. Thank you for the question, Mr. Chairman. This transaction is largely around Medicare Advantage, so I will speak to the Medicare Advantage marketplace and the Medicare marketplace in Iowa. Both Aetna and Humana have had very high quality scores. We both have markets—all of our markets are 80 percent or better from a four-plus-star rating, which seniors value. Over last year, at Aetna alone, over 85 percent of our enrollment was based on our quality rankings and our ability to provide an affordable product in the market.

Our rates have gone down 6 percent—have gone down—and yesterday a study was published from CMS. As a result of rate increases, rates will decrease by 31 cents per month for seniors across the United States next year.

We continue to see a decrease in pricing, a broader benefit structure for—and offering for seniors, and we view the product as high quality and very affordable. A vast majority of our members in both Humana and Aetna are low-income members, so we believe we are providing a valuable product and service to seniors.

Chairman GRASSLEY. Mr. Swedish, from your point of view?

Mr. SWEDISH. Thank you for the question. A very important question with respect to how we are going to engage in the marketplace regarding the combination of these two great companies. Anthem believes that there are three core pillars with respect to how we engage in the marketplace, focusing on provider collaboration, focusing on building out affordability for all of our customers, and then finally recognizing that this truly is a locally driven pursuit in terms of creating true value for customers.

Having said that, we believe that the synergies that we have identified will translate to benefits for the consumer, for instance, building out much more sophisticated, highly integrated information management systems that take real data, converting it into information that can best be used for delivering better care in terms of how the providers are engaging with their patients.

We believe that we will be able to combine that with many other opportunities that will drive premiums lower for our customers. That is certainly a commitment we have repeatedly made and have evidence to that effect today and believe that that will certainly play out going into the future as well.

Chairman GRASSLEY. Mr. Pollack, if the Department of Justice concludes that a merger would lead to high market concentration in particular markets, typically the remedy is for Justice to require divestiture. In both of your letters to DOJ regarding these deals, you appear skeptical that divestiture will remedy antitrust concerns.

Why don't you believe divestiture can remedy any antitrust concerns that may arise?

Mr. POLLACK. Thank you, Senator. Let's look at the notion of who would be a suitable acquirer in the arrangement as it relates to Aetna and Humana, where we have identified an impact to over 1,000 counties in 38 States that serve 2.7 million people. The question is who would be a suitable acquirer in that kind of divestiture arrangement, and given the scale of that proposed deal, as well as the other one, it just seems so large that finding someone that could come in and put together the networks and serve those communities would be a very difficult objective to achieve.

Chairman GRASSLEY. Mr. Chairman, because I have only got 11 seconds left, I am going to put my last question to Mr. Swedish in the record for answer in writing.

Chairman LEE. Without objection.

[The question of Senator Grassley appears as a submission for the record.]

Chairman LEE. Thank you. Senator Klobuchar.

Senator KLOBUCHAR. Thank you very much, Mr. Chairman. Thank you to the witnesses.

I guess I will start with you, Mr. Bertolini and Mr. Swedish, and you have explained what you see as some advantages of these mergers. Could you explain why you have to have these mergers to get to where you want to be? Because we have heard, you know, contrary testimony from some of the other witnesses. Mr. Bertolini?

Mr. BERTOLINI. Thank you, Ranking Member Klobuchar. We believe that our acquisition is not one of size but of capabilities. Humana has taken a step forward in making sure that health care can be provided in the home. As a matter of fact, in 2014 Humana had 496,000 more member days at home than they had in the prior year by providing care in the home and bringing the logistics of people, stuff, and technology to people's homes to make sure that they can live more productively, increasing healthy days.

Our view is that we want to acquire these capabilities and expand them and scale them across our business as part of our acquisition.

Senator KLOBUCHAR. Could you do that on your own without them, or you think——

Mr. BERTOLINI. We can do it on our own. It would take longer, and we believe that the need for affordability and higher-quality care is today, not in 3 or 4 years.

Senator KLOBUCHAR. Okay. Mr. Swedish.

Mr. SWEDISH. Yes, let me——

Senator KLOBUCHAR. Keep it short, because we have other questions.

Mr. SWEDISH. Let me begin with maybe a portrayal of what is being created. Two companies that have distinctly different portfolios that are highly complementary, where each company has obvious strengths, the other company will benefit from those strengths and vice versa. As an example, we—in terms of the complementary nature, we both are serving a very large national accounts environment.

Having said that, we also recognize that national accounts are typically administrative-services-only type arrangements, and in doing so, we then create the opportunity for those employers to get the benefit of the savings. It goes directly to those employers.

To get down to a more granular level, what we know is whether it is a national account or an individual account with respect to serving exchanges, this is all local. Every service we provide distills down to a local engagement.

Senator KLOBUCHAR. All right. Could I—I have some other questions. I wondered if some of the other witnesses-—if there are other factors. I went through what the Justice Department typically looks at. Do you think given the changes in this industry there are other factors that should be looking at? If anyone wants to take a stab at that.

Ms. DAFNY. Thanks, Senator Klobuchar. I will. I would argue that the Department of Justice will, of course, consider all factors as listed in the horizontal merger guidelines, but they might also spend some time thinking about the potential for a diminution of cross-market competition. There is evidence of that in the hospital industry, and it is possible that as these players have repeated contact with one another across different market segments and geographies, that might lessen the intensity of their competition.

Mr. POLLACK. Senator, we are not an expert on this, but I think one of the things—questions that needs to be looked at are the Blue Cross Blue Shield rules that give control over Blue lives in multiple States. There is an extensive interconnection among the Blue System, and the Anthem-Cigna deal will add to Blue dominance and create even larger barriers to entry. I think that that is something that also needs to be examined as well.

Senator KLOBUCHAR. Okay. In your testimony, Mr. Pollack, you talked about how you are against the consolidation on the insurance side, but basically you seem to believe we need more of it in the provider side. Could you reconcile that? Because we have had some consolidation, and there are some advantages to it, but it also, I think, has contributed to higher prices.

Mr. POLLACK. I appreciate that question. What we have seen in terms of price growth, as I said before, is hospital price growth is going up at one percent this past year, 1.3 percent the year before.

More significant, I think, is the objective of hospital consolidation. The objective of hospital consolidation is to bring together networks of caregivers that can move us in a direction to better coordinate care.

We did a study looking at hospital mergers over a 5-year period of which there were 607, or 12 percent, over that period of time. We found that when you looked at the 607, all but 22 of those mergers still left 5 hospitals in the market after the merger. If you look at the ones that did not fit that category, most of them were saving hospitals from going bankrupt or reconfiguring them in a different way so they could serve their community.

Senator KLOBUCHAR. Okay. Thank you.

Mr. Slover, would you agree with that, or are you concerned about consolidation on both ends?

Mr. SLOVER. We are concerned about all consolidation at any level, and it is a question—the benefits of the integration and coordination that we are hearing about here all make sense up to a point. Then the point where we get concerned is when it goes beyond being able to provide a better service, and becomes about being able to exert leverage over others to reduce their ability to make choices, and ultimately that reduces consumers' ability to make choices.

If there is a hospital network that has too much of the power in a local market, that reduces choices for providers and for insurers. Similarly, if there is a doctor group practice that has everybody, then they are the only game in town. I think it needs to be looked at across the board.

Senator KLOBUCHAR. Thank you.

Chairman LEE. Mr. Swedish, I will start with you. I have got a few questions at the outset about how Cigna would be integrated into Anthem's Blue Cross and Blue Shield plans.

My understanding is that, as a Member of the Blue Cross Blue Shield Association, Anthem is subject to something called the "best efforts rule," and correct me if I misstated this, but my understanding is it requires, among other things that no more than one-third of Anthem's total health care revenue may come from non-Blue-branded health plans.

My first question is: Wouldn't this limit your ability to compete under the Cigna brand if the merger were completed?

Mr. SWEDISH. Thank you for the question. There are a lot of characterizations about the Blue Cross Blue Shield organization and our part in that delivery distribution in the marketplace. You should know that we are in 14 States licensed as a Blue Cross Blue Shield plan. We do not compete in other States by way of the so-called license agreement we have with the association, so that we are strictly performing in those 14 States.

What will then happen with respect to the Cigna acquisition is the fact that in our so-called non-Blue States, those States outside of our 14-State domain, Cigna will compete; it will be a competitor in the marketplace competing against the Blue Cross Blue Shield plans in those States.

Within our own 14 States, the Cigna brand, the Cigna products may, in fact, come into our Blue Cross portfolio within those 14

States. However, in the national accounts space, it will still continue to compete as Cigna.

It is a combination of kind of placements in the country that are based on our Blue States and our non-Blue States where Cigna will, in fact, compete.

With respect to the best efforts rule that you brought up, we do need to comply with that rule, and we do not need to respond to the rule in terms of how we will comply until after the transaction closes, and then we will have 2 years thereafter to adjust our portfolio. We do not believe that that will be an impediment to the deal, nor do we believe that will present any kind of competitive deterioration in the marketplace.

Chairman LEE. Whereas today Cigna has every incentive, it is incentivized naturally as a result of market forces to compete as vigorously as possible and to fight for as much market share as possible, but won't the best efforts rule necessarily limit and cap Cigna's future competitiveness given that arrangement?

Mr. SWEDISH. Mr. Chairman, we believe that it is just the opposite, that our acquisition of Cigna will, in fact, make the Cigna brand stronger nationally in terms of the non-Blue States where they will compete against all plans. I think if there will be a significant upside to the Cigna brand in those markets with respect to whether it provides support to national accounts, large-group, or other methods that it will engage in the marketplace.

Chairman LEE. Okay. I have got another question now that I want to ask to both you and to Mr. Bertolini. Each of you talked a little bit about how customers, consumers would benefit from your respective transactions as a result of improved efforts in connection with value-based health care. Tell me how these benefits would be merger-specific? That is, why couldn't those benefits be achieved in the absence of the merger?

Mr. BERTOLINI. Thank you for the question, Mr. Chairman. In the—it is about, again, capabilities and presence in the marketplace, having a footprint of products that you are able to contract with the provider system. This discussion earlier of living in two worlds, fee-for-service and value-based insurance design, the more of the revenue that you can include in the new design, the easier it is for the provider to transition. From our point of view, having that opportunity to provide a broader breadth of products by market, where we can engage in a full conversation with the provider about changing their revenue model to a value-based model, is our intent.

Mr. SWEDISH. With respect to our engagement in the marketplace, we believe that there are three core elements: focus on the consumer, focus on the provider, and then focus on building value that is then delivered to the consumer.

With respect to value-based payment methodologies, and we probably can label them "alternative payment models," just within the last 3 years we have built out a value-based payment reimbursement effort that now totals 53 percent of all of our payments to providers being value-based. We have an infrastructure now then combined with the Cigna infrastructure that we believe will accelerate at a very fast pace value-based payments to the marketplace, value that then does go to the consumer.

As an example, we have 150 ACOs, Cigna has 114 ACOs. We have 780 hospitals that are now affiliated with us and these alternative payment methodologies with over 100,000 physicians that are participating. Cigna has likewise built a very elegant infrastructure that, in alignment with us and engaging in the marketplace, we believe we will deliver tremendous uptake in value that will benefit the consumer.

Chairman LEE. Thank you. Senator Franken.

Senator FRANKEN. We are not going to recess for votes now?

Chairman LEE. We may be recessing in——

Senator FRANKEN. I can get through this? Okay.

I am going to depart from where I was going to go, but I was just listening to Mr. Swedish's answers on Cigna now which is competing in MA—or is competing against Blue Cross Blue Shield, will not be able to. I saw some skepticism about your answers, and I want to make these answers short. Dr. Dafny, did you share with me a little skepticism? Because I think that all the Cigna plans will not be able to compete with the Blue plans in many of these markets.

Dr. DAFNY. Thank you for the question, Senator Franken. My first response is with regard to the national plans, the notion that Anthem and Cigna would continue competing in that segment. They are going to be the same entity, so they might have two names, but I do not see how that is competition.

With respect to whether the agreements with the Blue Cross and Blue Shield Association would inhibit the expansion of Cigna as a brand, that very much depends on how big they are in the various markets and whether they would exceed the thresholds. I would say I sure wish I had the data to assess the veracity of the claim that that constraint is not binding.

Senator FRANKEN. Okay. I am going to continue on because you spoke to that—I am sorry? I have got to go pretty soon to vote. Okay. Let me try to do this fast. Mr. Slover, I wrote the medical loss ratio provision of the ACA, which everyone knows requires insurers to pay at least 80 percent—85 percent of their premium dollars on actual health care, for large groups, 85. MLR has saved literally billions of dollars for consumers.

I am just a little worried about a couple things. Dr. Dafny said something about that it could be repealed. I hope not. Can you talk to how MLR has been saving money for consumers and made competition better in the insurance markets?

Mr. SLOVER. Yes, Senator. We are strong supporters of the medical loss ratio requirement. We are very glad it is in the law. It has brought tremendous benefits to consumers, as you indicated, billions of dollars, and it has disciplined insurer spending. It works only in that one dimension—it is working very well in that one dimension—to put a floor on the percentage of premiums that has to go to paying for health care and quality improvements.

It does not address the other ways that competition can be affected by mergers, and if we lose the competition among insurance companies in the non-price ways—competition is not just about price, although price is maybe the easiest way to measure it. And so we think that for all of the great work that the MLR has done, it works better in conjunction with a competitive marketplace.

Senator FRANKEN. Absolutely.

Mr. Bertolini and Mr. Swedish, you both described how savings will be passed along to consumers, so are you saying that you will commit passing these savings on to your policy holders?

Mr. BERTOLINI. It is our intention to make our products more affordable, and we commit to continue to drive affordability across the system in the changing relationship with providers.

Senator FRANKEN. That is not quite an answer to my question.

Mr. BERTOLINI. Okay.

Senator FRANKEN. Do you commit to passing along savings to your policy holders?

Mr. BERTOLINI. Which savings are you referring to, Senator?

Senator FRANKEN. The savings that you will have by virtue of being able to do this merger.

Mr. BERTOLINI. We will need to do that and more in order to make products more affordable going forward.

Senator FRANKEN. That is not quite an answer. Will you commit to passing along the savings to your policy holders?

Mr. BERTOLINI. Our savings will be passed along in the price of our product.

Senator FRANKEN. Mr. Swedish, do you commit to passing along the savings, all of the savings to your policy holders?

Mr. SWEDISH. We are committed to driving affordability for all of our customers. We are committed to balancing the investments that are necessary to improve our products for the benefit of our consumers. I believe by definition that generates savings that goes to the consumer.

Senator FRANKEN. Do you commit to pass those savings on to the consumers?

Mr. SWEDISH. We will certainly do so to the extent that we are providing a very balanced portfolio of offerings to the marketplace that is driven by great value, driven by the desire that the customers want us to address, and, again, I do believe that all translates to improved distribution of savings to the consumer.

Senator FRANKEN. I am out of time. I do think that we could have gone quicker if those answers were, "Yes."

Chairman LEE. Okay. I am going to go vote right now. Senator Hatch is going to assume the gavel while he does his questioning for the next few minutes. I am going to be very fast. I hope I will be back by the time he finishes. If not, we will go into a recess for a few minutes until Senator Klobuchar and I are back.

Senator Hatch.

Senator HATCH. [Presiding.] Thank you, Mr. Chairman.

Let me just ask this question to Mr. Bertolini and Mr. Swedish. Opponents of the merger argue that entry into a commercial health insurance market is difficult because it requires an entrant to assemble a broad provider network and obtain prices and discounts comparable to leading incumbents. Do you agree with that view? I would like to have an answer from both of you. If so, why or why not?

Mr. BERTOLINI. Senator Hatch, our acquisition is largely a Medicare Advantage combination, so there will be very little impact, if any, on the commercial marketplace, and we see no competitive impact related to all market entrants.

However, there are 400 commercial insurer competitors in the marketplace today. There are new entrants, 75 in the last three years on the public exchanges as they begin to offer more products and services. We think there is a robust competitive market. There are ten in the overlap markets between Aetna and Humana. There are ten commercial competitors in the public exchange markets today.

Senator HATCH. Mr. Swedish.

Mr. SWEDISH. Yes, sir. Thank you for the question, Senator. Initially, when you take what we offer in the market and dissect it, looking at products related to small-group, appreciate the fact that the relationship with Cigna and Anthem presents absolutely no overlap in the sense that Cigna does not support the small-group marketplace. There is no competitive threat there.

Number two, if you look at the individual space—and this is critically important—we are both in many States. We only overlap in five States. What is fascinating about it is that the choices to the consumer in the individual space is incredibly robust. They can now choose from an average of 40 health plans in terms of being able to secure health insurance coverage for their access into the individual market.

We have witnessed tremendous growth in the number of plans serving the marketplace. As an example, we have witnessed the fact that a lot of provider health care delivery systems now are offering health insurance products to the marketplace.

Again, I believe competition is robust. The entry points are many, and it is producing tremendous opportunity for the market to receive products and services for many health plans going forward.

Senator HATCH. Thank you, sir.

Mr. Slover, based on past experience, how likely are enrollees to change plans when premiums go up or benefits are cut? If a post-merger Aetna or a post-merger Anthem were to raise prices or degrade service, how likely is it that they would lose subscribers?

Mr. SLOVER. There probably is some sticking effect up to a point, where consumers are going to stay with who they have got and employers are going to stay with who they have got. It is important that they have a choice, another place to go, and a place where they can get as good coverage as they had before, or better coverage, at a more affordable price, and to have those insurers competing against each other to hold each other in check. What we are concerned about—and this is something that the Justice Department is going to have to look at in each one of these markets—is how this combination is going to affect that and is going to risk losing that benefit.

Senator HATCH. Could I have you two, Mr. Bertolini and Mr. Swedish, can you comment on his comments?

Mr. BERTOLINI. Senator, all—like politics, all health care is local, and there are many competitors and a lot of variability in each marketplace.

In the Medicare Advantage space, where we are, which was the large driver behind our acquisition, there are 18 different plan options available to seniors, and in nonrural markets and in rural markets, there are 10. We view the ability for lots of choice still

available. Medicare Advantage rates have dropped 6 percent since 2010, and the benchmark, the Government benchmark against which we compete is still dropping every year, and so we see the market still very competitive.

Wall Street is investing in new entrants into the marketplace. The plan called Oscar, which entered the New York market, a very large market, just received a $32.5 million investment from Google to open that marketplace up.

Senator HATCH. Mr. Swedish.

Mr. SWEDISH. Senator, I can simply underscore what Mr. Bertolini brought out by referencing Dr. Ginsburg's paper. On page five, he speaks to the growth in just one sector of the industry, and he states that, "A recent Avalere Health analysis reports that 15 of the 28 new entrants into Medicare Advantage between 2012 and 2015 are, in fact, health systems and 37 provider sponsored plans offer coverage on public exchanges."

I simply want to underscore that there are many new entrants to the marketplace, Oscar being one. That is probably more recent and called out quite frequently as an entrant that is having great success in the marketplace.

Again, competition is becoming more robust in every sector of the health plan marketplace.

Senator HATCH. Professor Ginsburg, what is the relevant market or markets here?

Dr. GINSBURG. Excuse me, sir?

Senator HATCH. What is the relevant market or markets here?

Dr. GINSBURG. Two markets have become particularly easy to enter and we are seeing entrants. One is the individual market, which is a result of the public exchanges, and the other is Medicare Advantage. I am not seeing that much entry in other markets, but as the other witnesses have said, the individual and Medicare Advantage markets are becoming more competitive.

Senator HATCH. Is it the national market—is it each State market or is it some number of smaller geographic markets that—and should traditional Medicare and Medicare Advantage be considered part of the same market or different markets? What is the right way to define the health insurance market? I guess that is what I am getting down to.

Dr. GINSBURG. It is very challenging. In some markets, those for individuals, for small groups, for some of the large-group markets, are very local. Medicare Advantage plans have very local markets. For large self-insured employers, a lot of that is a national market. That is quite distinct.

Senator HATCH. Would you care to comment, Professor Dafny?

Dr. DAFNY. I would concur that market definition depends on the access channel on the specific customer segment, and it would be different for commercial populations and for Medicare Advantage populations most likely.

Senator HATCH. Thank you.

Let me go back to you again, Mr. Bertolini and Mr. Swedish. Mr. Bertolini, the American Hospital Association has argued that the Aetna-Humana merger would increase the HHI score for Medicare Advantage by over 200 points in 1,924 highly concentrated markets

and by over 100 points in another 159 highly concentrated markets.

Mr. Swedish, the association has similarly argued that the Anthem-Cigna merger would increase the HHI score for commercial health insurance by over 200 points in 600 highly concentrated markets and by over 100 points in another 217 highly concentrated markets.

You first, Mr. Bertolini, but then Mr. Swedish, do you agree with those calculations? If not, why not? I would like to know, anyway. If those calculations are correct, does that mean that the mergers will presumptively increase market power? You can go first, Mr. Bertolini.

Mr. BERTOLINI. Thank you, Senator. I will point to a comment that Dr. Ginsburg made earlier, that market concentration is just one measure of looking at potentially anticompetitive issues. I am not an expert on the HH Index. I have enough to do in my day job to manage all that I can think about relative to medical loss ratios and the like.

What I would say is that as we look at the markets where Aetna and Humana compete, again, we have 18 competitors in nonrural markets, and in rural markets we have 10 competitors—10 plans offered, and 18 plans offered in nonrural markets. We see plenty of competition, plenty of entrants. The 28 entrants over the last 3 years have been more than half hospital systems, and we view that in the event we get to a point with the Department of Justice where we need to engage in any divestitures, that there will be hospital systems that will want to have another particular to enter the Medicare Advantage market.

Thank you.

Senator HATCH. Mr. Swedish.

Mr. SWEDISH. Senator, likewise, I am not completely familiar with the analytics that you mentioned, and, in particular, the research results that have been referenced. I would rather respond back to the Committee at another time maybe for the record very soon, and, of course, to the Department of Justice regarding their assessment of the combination of these two companies. That is probably the best I can offer at the moment.

Senator HATCH. Thank you. It has been interesting to me.

I am supposed to recess until further notice. I think they will be back shortly from their votes. We will just recess until the Senators get back.

[Whereupon the hearing was recessed and reconvened.]

Chairman LEE. We are ready to reconvene. Senator Klobuchar is next.

Senator KLOBUCHAR. Thank you very much, Mr. Chairman.

I talked a little bit about the health insurance consolidation, and I know we had some quick answers there from both of you. We have a little more luxury of time now. If you could finish up, Mr. Swedish, I was asking you, remember, about why you needed the merger to achieve some of these cost goals that you have.

Mr. SWEDISH. Thank you for the follow-up question. What I would like to do is maybe describe to you the various products and services that we do offer in terms of how we segment our business.

This is a highly segmented industry that then serves a very focused effort in and around the local markets.

For instance, we are very active, as is Cigna, in the national marketplace serving large accounts, large national accounts. These are very sophisticated, highly educated buyers of health care services, typically using consultants who then they rely upon to make the selections for the health plan that will serve them in the national market space that they reside in. Typically they will choose two or even three health plans. Again, very competitive landscape in the national account marketplace.

Specific to your question about why come together, we will both be better able to serve that customer base of national accounts that really highly desires our support as an administrative-services-only support team to what they need in terms of health plan delivery.

What is fascinating, when people ask about the competitive landscape specific to national accounts, is that there are 130 unique health benefit companies serving that self-insured marketplace. In 2014, there were 30 new companies that began competing in that space. The GAO reported in 2014 that there is an average of 11 insurers competing in that large-group market for specific contracts. You can see that the combination of our two companies in an area where we are most active is very valuable to the customer.

Let me briefly go to another environment. Small-group, while you were out I mentioned we do not cross over at all. They do not have small-group. We will continue our small-group coverage and competition in the markets we serve.

With respect to the individual space, especially in an exchange environment, they have a very small market presence in the individual space, and today consumers can choose from an average of 40 plans that support their choices, and in that regard it is all about choice. Whether it is a national account, small-group, individual plans, we are coming together.

Finally, the complementary nature of the two companies allows us to combine to then access their expertise in the international market, which we do not have a presence in that space.

Finally, services like wellness programs are very vital to moving the needle on value for the customer, and Cigna has a phenomenal wellness program that will integrate with us, which then translates to more value to the consumer.

The combination of all those products and services really brings value to the marketplace that I would argue is exponentially more significant in value than what we can offer as stand-alone organizations. Thematically, we both believe one and one equals three in terms of the combination, in terms of how we can serve the customer.

Senator KLOBUCHAR. Dr. Ginsburg and Dr. Dafny, you both have these studies that you are relying on on consolidation that you have talked about. Could you just explain them in more layman or laywoman's terms, which is where do you see this market going, and when you kind of look at the big picture view and how it is going to affect consumers? Maybe you want to start, Dr. Ginsburg.

Dr. GINSBURG. I would say that the——

Senator KLOBUCHAR. Your microphone, there.

Dr. GINSBURG. The literature on insurer consolidation is a very limited one. Professor Dafny's study of the Aetna-Prudential merger, which was 15 years ago, is well regarded. She also explained how difficult it is to do these studies. The information on provider mergers is much clearer and——

Senator KLOBUCHAR. What does that show?

Dr. GINSBURG. That hospital mergers lead to higher prices without an impact on quality. This is a very extensive literature that has been synthesized by very good people.

Nevertheless, there are other dimensions that are quite relevant besides consolidation. Policy can make some markets much more competitive, and this has happened in the Affordable Care Act.

Senator KLOBUCHAR. That is right. You know, we do have a lot of that in our State because with the geographic disparities between parts of the country and the fact that certain States in certain regions of the country seem to have had in place historically more incentives or a different culture that makes things more cost-effective and higher quality, and that is certainly what we have in our State. That is what I was kind of trying to get at, too, that could be a potential solution here because it still—the Affordable Care Act has those incentives, but we still have not seen the full results of them. We have seen some.

Dr. GINSBURG. Yes. One of the upsides to consider—and perhaps not overdo it—is that we are placing a lot—a big bet as a country in alternative payment models—value payments. It is really the only thing we have got to try to address costs on a long-term basis. There are some situations where insurer consolidation can lead to this trend moving forward more rapidly. The role of Medicare has been and will be very important in this trend because providers need to move all of their—eventually all of their patients from fee-for-service to value payment models.

Senator KLOBUCHAR. Dr. Dafny.

Dr. DAFNY. If I may, I am delighted by the question, what can we learn from prior research on this. In addition to the discussion of the Aetna-Prudential merger, there is a study on another large merger in Nevada, United and Sierra, that found large increases of 14 percent in small-group premiums. I have myself done a study on the individual insurance exchanges which demonstrates that competition on exchanges also leads to lower prices. In particular, one of the large nationals sat out in the first year, and we estimate that in those areas where they had a bigger presence in the individual insurance market, premiums on the exchanges were higher. Competition matters. It matters today. It mattered then.

Senator KLOBUCHAR. Okay. Very good. Thank you.

Chairman LEE. Senator Blumenthal.

Senator BLUMENTHAL. Thank you, Chairman Lee. Thank you all for being here today and for the excellent testimony you have offered so far.

I am deeply concerned about these mergers because of the potential effect on competition and the concentration of power in fewer hands. I have expressed those concerns publicly. In some sense, I have a feeling that, like the saying about marriage, that this merger may be the triumph of hope over experience. The experience that is suggested by a lot of the scholarship done in this area is that

consolidation is so rapidly taking over this industry, and we have seen it in other industries, and we have seen the consequences of it in higher prices, in this instance potentially higher premiums. I am deeply troubled by the evidence that shows that neither providers nor consumers benefit from these consolidations; in other words, that the Prudential-Aetna experience shows that premiums are not lower, that consumers do not benefit, and that the savings are not passed along to consumers.

When viewed together, I think both of these proposed deals raise those serious competitive concerns, and in addition to conducting a market-by-market analysis, I believe that the Department of Justice also must scrutinize these mergers together, all together, as part of a single national health care market. The goal has to be to sustain and enhance, if possible, competition and protecting consumers.

I want to focus in particular on an area that has not been covered so far, and that is the issue about barriers to entry. As you may know, in 2010 former Assistant Attorney General Christine Varney explained the results of a review of the Antitrust Division into the question of barriers to entry in the insurance marketplace, and this was her conclusion before the American Bar Association quote: "Our conclusions reinforce our concern about strong barriers to entry and expansion in health insurance markets and are particularly significant in light of the enactment of the Affordable Care Act. It is, therefore, imperative that the Division prevent mergers or acquisitions that will create or even increase the size of dominant health insurance plans, particularly in the small-group and individual markets. Entry defenses in the health insurance industry generally will be viewed with skepticism"—she was talking about the DOJ—"and will almost never justify an otherwise anticompetitive merger."

The suggestion has been made—and I think it is a pillar of the argument for this merger—that these barriers to entry are insignificant, and I think experience belies that contention, as Assistant Attorney General Varney explained.

I would like responses from Mr. Bertolini and Mr. Swedish, if you would, please.

Mr. BERTOLINI. Thank you for the question, Senator. I understand your point of view. I would like to make clear what the data shows us in the markets where we compete.

In Medicare Advantage, there is plenty of competition: 28 new entrants, more than half hospital systems over the last 3 years; more and more hospital provider systems are entering the market; more than 70 new competitors on the public exchanges. In the public exchanges where we have overlap between Aetna and Humana, there are at least 10 other competitors.

Investments by Wall Street, private equity and venture capital into health care, starting new health plans, as evidenced by Oscar in New York where Google just this last week invested $32.5 million in furthering their expansion in the New York marketplace.

All health care is local, just like politics. At the local level, we continue to see more and more entrants, and we continue to see more competition. We are not at all concerned about the lack of competition in the local markets.

In Medicare Advantage specifically, the Government sets a benchmark which it requires us to beat in order to offer a zero premium plan to consumers, and so we have over the last 5 years, from 2010, reduced rates by 6 percent in Medicare Advantage to the benefit of seniors both with a higher-quality product and a more affordable product each year.

Senator BLUMENTHAL. Mr. Swedish.

Mr. SWEDISH. Thank you, Senator. If I understand the question, it is dealing with barriers to entry and the perception that barriers do exist such that new entrants cannot come into the marketplace.

Senator BLUMENTHAL. There are powerful barriers to entry, notwithstanding what Mr. Bertolini said. I understand your point and I respect it. I cannot just start an insurance company that will have any hope of competing with the combined entity once this transaction is completed. Yes, all health care is local, like all politics is local, but there is national politics, there are national markets, and those markets are profoundly important for the Department of Justice to review in scrutinizing this merger because of the barriers to entry. That is true of other industries as well. That is the perspective that prompts my question.

Mr. SWEDISH. Yes, sir, and I certainly appreciate that perspective. What I can share with you is that there are many new players that have entered the market and continue to enter the market. What I would like to do is begin with the reference to Oscar that Mr. Bertolini just brought up: Serving New York and New Jersey, year one of their entry into that highly competitive marketplace, they accumulated 45,000 new members, and the company was founded based on venture capital funds and just recently a Google investment that will accelerate their engagement in the marketplace by them going to California next year. Again, one company, multiple products, demonstrated success in year one.

Let me underscore maybe the bigger view. As we deal with the national marketplace for large-group and national accounts, what we have witnessed is 30 new companies that have entered the marketplace competing in the national accounts sector. The GAO report brought out the fact that, on average, there are 11 insurers competing with—amongst themselves for national accounts.

With respect to another slice of development in the marketplace, PwC in 2014 revealed that 50 percent of U.S. health care systems have or intend to apply for an insurance license. In fact, it was just brought out a little while ago that, with respect to serving public exchanges, 37 provider-sponsored plans now are in the marketplace offering coverage for enrollees in the exchange environment.

My point is that competition is becoming more robust, not less. With respect to our combination with Cigna, quite frankly, we are compatible and complementary companies without a lot of overlap in how we engage in the marketplace. In that regard, I believe we will bring great value to our customers and we will compete very effectively in the marketplace by virtue of this combination.

Senator BLUMENTHAL. My time has expired. I want to thank both of you for your very informative responses. I think we have only begun to scratch the surface in terms of the data and the material that has to be reviewed by the Department of Justice, and I hope that the scrutiny will be exacting and demanding, as I know you

expect it will be. There seem to be two very different factually ground perspectives here—one offered by Professor Dafny in the charts and testimony that she has offered, and the other that you have presented. I think it may result from the way markets are sliced and diced in the different analyses that are done, and my hope is that the Department of Justice will look at the national market rather than only the local markets, because insurance is not all local. Thank you.

Thanks, Mr. Chairman.

Chairman LEE. Senator Tillis.

Senator TILLIS. Thank you, Mr. Chair. I want to welcome all the panelists. Thank you for your testimony. I was here for the testimony, and I apologize. I had another meeting, a vote, and another meeting, and then another meeting before I got back here. It is not for lack of interest, and I will certainly be reviewing some of the comments from some of my colleagues.

You know, this is a very complex process, not only the issues that you have to deal with in terms of the geographic market, the competition, the saturation, all these other things, a number of the things that Dr. Dafny mentioned that go beyond, I think, the things that we tend to look at.

I for one am glad that Congress saw their way fit to make this task something that the DOJ would do for a variety reasons, one I will get to in a minute.

You know, as far as I am concerned, market concentration is what I do when I am at the grocery store and trying to figure out what my wife asked me to buy when I went there. The way that you are looking at market concentration here and all the other factors I think is appropriately in an area that should be making judgments on a nonpolitical basis, on the merits of the deal based on factors that have been outlined.

Here is a concern that I have with this particular transaction. It has been alluded to by some of the comments today. You know, different public policies that have been outside forces that are causing some of these things to occur, either in the insurance industry or in the hospital industry.

My question is: Do you feel like in light of particularly even some biases on the administration's part about where we should go with health care in the future in this Nation, do you feel like that the process that we have in place in the DOJ is likely to produce a decision based on the parameters set forth versus something that may potentially be influenced by an outcome that better serves a legacy agenda item? I will start with—actually, I will start with Dr. Ginsburg.

Dr. GINSBURG. Certainly the Department of Justice is guided by the age-old antitrust laws, which have served the country very well. Clearly there are judgments that are hard judgments to make, and I really cannot get into the minds of the officials in the Justice Department as to how they will come out. I think they are committed to a very extensive review.

Senator TILLIS. Mr. Bertolini, what are your thoughts.

Mr. BERTOLINI. Senator, I believe the process is very thorough and complete, and we expect that it will be a fair and appropriate process.

Senator TILLIS. Dr. Dafny, you mentioned—and I am a data person myself. I ran a data analytics practice back before I entered politics. Do you feel like the process today—do you have enough insights into the process now? It may be that you and I may be coming from a different frame about the argument that the data would support. Do you feel like the process appropriately incorporates considerations for the kinds of things that you look at when you are studying this?

Dr. DAFNY. I am confident in the process of the Department of Justice. I just wish that the public had some access to the information so that we could perform analyses, too.

Senator TILLIS. I think that is a valid point in terms of transparency. I understand some of the competitive elements that have to be taken into account.

I have another question, and it seems to me that one trend would cause the other trend to occur. I know in North Carolina we have had a lot of consolidations. To your point, Mr. Pollack, we have had hospitals, problem hospitals in rural areas that were acquired and but for that may have been out of business, diminishing our ability to serve the rural population, which is the most underserved at least in North Carolina, probably nationally.

By the same token, that consolidation, you had mentioned how it has improved outcomes and possibly improved the delivery of services. It has also created large provider networks. One of the advantages to the kinds of mergers that we are talking about here is that—and I am not missing the sumo wrestler analogy that Mr. Slover gave, but as long as that trend continues, it seems to me that, as someone who also was involved in strategic sourcing and supplier negotiations, that there is a valid argument that, to the extent that you have a larger buyer base, strategic sourcing base, you are probably going to be able to negotiate better price points not only for medical services provided but also addressing a very serious problem about the cost of pharmaceuticals.

I will start with Mr. Swedish and then, time provided or Chair allowing, have at least one other person respond. Thank you.

Mr. SWEDISH. Thank you, Senator. If I understand the question, it is about provider consolidation and the——

Senator TILLIS. No, I am looking at—provider consolidation is something that the hospital industry has used as an argument for improving care and reducing cost. I would think that a part of your argument—there is very clearly a model that you want to adopt and have pervasive in terms of the products and the services you provide. What I am getting to is the business of your business, where you have got to get out there and ultimately negotiate provider rates that can fit within the models that ultimately bend the cost curve, reduce the cost of pharmaceuticals, reduce the cost of the medical services provided.

My point is it seems inconsistent to argue that the consolidation of hospitals to address their challenges is okay but the consolidation of insurance companies, if they fit within the DOJ constraints for such a merger, would not be okay. I am just trying to understand why that is inconsistent or not inconsistent.

Mr. SWEDISH. Thank you for that clarity, Senator. If you can indulge me, I would like to give you a tale of two cities.

One, as I mentioned earlier, our organization, Anthem, has developed a value-based payment infrastructure that today 53 percent of our payments to providers are value-based driven, i.e., alternative payment models. We have got 106,000 physicians that are participating in those models that I think, as they say, vote with their feet. They are part of the models going forward, to your point.

Cigna's infrastructure likewise has multiple models, ACOs and a variety of value-based payment models as well that will integrate with our model at the close of the transaction.

However, let me shift now to a different perspective. As you heard earlier, I served as a provider executive CEO for many integrated delivery systems, in the State of North Carolina, quite frankly, for probably 15 years, so I know those delivery systems extremely well. I have keenly observed the combinations and consolidations happening on that front, so I am well aware of what is happening in that State, as well as 49 other States, given the view that I have today from my perch as a health plan executive.

What I can tell you about my lived experience in that world is that for the last 15 years, we were focused heavily on acquisitions, consolidations, purchasing hospitals, purchasing physician practices, all built under the premise that we are going to be clinically integrated.

I would further submit that the buildout had a lot to do with negotiating better price. It was all about negotiating better price by way of delivering better quality.

I would argue today in terms of our commitment to value payment, our commitment to new models of care delivery, supporting practitioners with data that gives them legitimate information to better manage care, I think today is a totally different day than what history suggests in terms of what the old story looked like versus what it looks like today and what it will look like going forward.

I think competition is robust, but, more importantly, our alignment with providers is value-added to the new markets that we have come upon. Relative to whether it is small group, large group, ACA-related, it is all connected in terms of the value to the market.

Senator TILLIS. Thank you. I am sorry. My time has expired. If any of you have feedback on that, I would like to have that communicated back to my office. I would welcome it.

Thank you, Mr. Chair.

Chairman LEE. Senator Coons.

Senator COONS. Thank you, Mr. Chairman and Ranking Member, for holding this hearing, and to all of you. I have had a chance to review much of your testimony, so I will be fairly brief given that a vote has just been called and this has already been a very long hearing for many of you.

If I might, to Mr. Swedish, your testimony highlights some of the important quality initiatives and partnerships between Anthem and Cigna, and as someone who has been intimately aware of Cigna's work in terms of transparency and improving the patient outcomes and quality, how will these partnerships or programs either expand or increase after the merger or be negatively impacted by the merger? What kind of metrics will you be using to make

sure that they continue and that they continue to have a positive impact on patient outcome?

Mr. SWEDISH. Senator, thank you for the question, because I think it really just does speak to the future state—and future state with respect to how we envision it lays out a very strong model of building on the respective successes of both organizations.

As I mentioned before, I believe, Cigna has built out a wonderful model in and around accountable care delivery methodologies. They have generated a situation where patients, their members, are more compliant with diabetes measures to the extent somewhere on the order of 25 percent improvement. They have witnessed a 45-percent lower medical cost trend versus the industry at large. That is a wonderful asset to capture in terms of blending with our own successes in like fashion with respect to how we have administered our services in the 14 Blue States that we oversee.

Long story, short, I think the combination will be synergistic in nature, and clinical performance will be greatly advanced by way of one key asset combination: data, taking data repositories, respective data repositories, melding them together in order to create valued information for the provider community.

I believe care delivery will ultimately get better because, number one, our stewardship of that data and the stewardship that we then administer in terms of our partnership with physicians will become more enhanced by virtue of the benefits and the strengths of both companies coming together clinically.

Senator COONS. My last question, if I might. A number of you have talked about how the insurance market is either national or really local, and I think there is an enduring tension between the perspectives offered today about whether it should be looked at and measured nationally or locally. I am going to ask a very parochial concern, being from Delaware, because Anthem has about 100 folks doing data analysis and Cigna has about 500 folks who I fought very hard for, who are critical to the expatriate health insurance program that has been administered out of there.

What sort of opportunities do you see, should there be a merger, post-merger for increasing your footprint in my home State? What sort of risks do you think there are to the significant employer base for my little State that your two companies represent? Do you think that given the lack of competition in the marketplace in Delaware and what a significant negative impact I think that has had in some ways, what opportunities do you think there might be for expanded opportunities on either the individual exchange or on other market segments?

Mr. SWEDISH. Senator, I appreciate your comment about the workforce in Delaware. Let me first underscore that we are vitally concerned about all of our associates nationally. We really focus heavily on building a culture that is rooted in our commitment to creating value in the marketplace. I do want to State that on a national basis, national perspective. That is critically important in terms of our relationship and support of all of our associates.

With respect to Delaware, I recognize that HealthCore is headquartered there, which is a division that is analytically driven, engaging with pharmaceutical enterprises to effectively analyze the benefit of pharmaceutical products that go to market, with about

100, 150 associates. With respect to Cigna's presence, they have an incredibly successful international outreach, i.e., going global, as you know. The number of associates probably approaches 500-plus.

Our sense is that certainly will remain in Delaware. It is a critical contributor to the Delaware economy. We recognize that and, quite frankly, underscore the fact being a growth-oriented enterprise, we would expect both of those areas with respect to international services as well as research to continue to grow.

Thank you.

Senator COONS. Thank you.

Thank you, Mr. Chair, and I would like to thank the panel.

Chairman LEE. Thank you, Mr. Coons.

Mr. Pollack, some industry observers have suggested that these mergers might provide some necessary and helpful countervailing market pressure to sort of balance out the widespread consolidation that is starting to occur among providers, specifically providers who are getting into the business of offering insurance plans. What is your response to that suggestion?

Mr. POLLACK. I think it is just the opposite. You know, right now the insurance field is already incredibly consolidated. We were talking earlier about barriers to entry, and there have been studies from both Kaiser—Kaiser Family Foundation and the Commonwealth Fund talking about how 97 percent of the Medicare Advantage markets lack competition. If you look at the breadth of Blue Cross Blue Shield plans, in 40 of the 50 States they are the largest plan. We think that you need to have continued robust competition, which leads to innovation, and we do not see how these deals promote that aspect of it.

As for the provider-based plans, while they are out there and they are growing, they pale in comparison in terms of scale to what we have seen with regard to the commercial insurance company side of this environment. While the provider-based plans actually bring great value and get great quality ratings, it is still hard in the face of competition from some of these other commercial entities to, in fact, get into these markets. Very often you have to have a minimum number of lives, which it is sometimes very difficult for these provider-based plans to acquire.

Chairman LEE. They do not weigh the same. That is one way of putting it.

Mr. POLLACK. Exactly.

Chairman LEE. Okay. I want to get back to Mr. Bertolini and Mr. Swedish. I am sensing you wanted to respond to that. You can work that into your answer on this question. They are kind of connected. I have got questions for both of you. Both of your companies have represented that entry into health insurance markets is relatively easy. If that is the case, why not enter into the markets that Humana and Cigna are already in? Why not enter into those instead of buying those competitors? For example, why can't Aetna just expand its Medicare Advantage offerings instead of buying Humana? Why can't Anthem expand its services instead of buying Cigna? I would like your reaction to that and also just any thoughts you have got about whether new entrants are likely to remain in the marketplace, whether that makes a difference.

Mr. BERTOLINI. Thank you, Mr. Chairman. I think the tradeoff as to whether or not to enter markets versus acquire markets is simply an economic discussion. How do we want to deploy our capital and how quickly do we want to get there?

Aetna was going to spend the next 5 years getting into markets that covered 70 percent of the Medicare eligibles. Why is that important? Because seniors are now more portable. They need to move around, and they want to keep the kind of quality and benefits that we offer at the prices we offer to them, which in a lot of cases, more than half, are zero premium policies for full benefits.

With this acquisition, when it closes, if appropriate, then we will be in markets covering 92 percent of the Medicare eligibles across the country so that they have that portability and are able to move around.

Chairman LEE. Mr. Swedish.

Mr. SWEDISH. I can probably echo some of the same comments, but with respect to being specific to our combination, you know, certainly we have spent considerable time analyzing the economics of the transaction, the value add to our members, but, more importantly, pivoting as an organization at a very fast pace relative to how fast the market is changing and the demands of the consumers are changing, whether it is a national account, small-group, individual. You know, any segment you want to look at, the turbulence, the speed of change in the marketplace necessitates a combination that brings new value to the marketplace. In that regard, we believe this economic combination makes a lot of sense for us because we can come to market faster, better, and then in turn create more value for the consumers. Otherwise, quite frankly, we are dragging with respect to the responsiveness that we believe is necessary to best serve the marketplace.

Final analysis, we are going to craft and administer a transaction that truly is in the best interests of not only our consumers but also the business itself in terms of being a sustainable business going forward. We believe this combination creates both sustainability and support to the customer in equal fashion.

Chairman LEE. Thank you. I have got additional questions, but in the interest of time, given that there has been another vote called and we have got to get to that vote, I am going to go ahead and adjourn the hearing, and we will submit any additional questions in writing.

Chairman LEE. Senator Klobuchar, before we adjourn, do you have any additional remarks?

Senator KLOBUCHAR. No. I appreciate you holding this hearing. It is really important, and I assume we will have more to come. Thank you.

Chairman LEE. Thanks to all of you for your participation. This has been very helpful. Thank you for being here today. We are adjourned.

[Whereupon, at 12:13 p.m., the hearing was adjourned.]

[Additional material submitted for the record follows.]

A P P E N D I X

Mark T. Bertolini

Chairman and Chief Executive Officer

Aetna, Inc.

United States Senate Committee on the Judiciary

Subcommittee on Antitrust, Competition Policy and Consumer Rights

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

September 22, 2015

I. Introduction

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

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

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

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

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

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

II. Dynamic and Changing Industry

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

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

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

Consumer Engagement

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

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

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

III. Fundamental Shift in Health Care Delivery

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Competition Will Also Remain Strong in Other Products

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

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

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

V. Benefits of the Acquisition for Consumers and Providers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Measuring Healthy Days

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

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

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

VI. Next Steps

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

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

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

VII. Conclusion

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

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

Attachment 1 – Background Information About Aetna and Humana

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

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

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

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

Prepared Statement of

Joseph Swedish, President & CEO, Anthem, Inc.

Before the

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Subcommittee on Antitrust, Competition Policy, and Consumer Rights

On

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

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

Health care in our country is rapidly evolving, driven by the needs of consumers, who demand change from all sectors – providers and payers. Neither payers nor providers alone can bring about the change necessary to close the gap between consumer expectations and the outcomes that the health care system has historically delivered. Nor can this change be achieved by Anthem or Cigna alone. No longer is it enough for health insurers to serve as financial stewards in the health care delivery transaction; we must now assist consumers as they interact with the health care system, not just in choosing the health care options that best meet their needs, but also in helping them decide how and where to access care.

Likewise, we must go beyond paying claims, instead partnering with providers by offering human and financial resource support, actionable data analytics, and tools that further their efforts to focus on the health of their patients, while shifting from volume- to value-based payments. And above all, we must help all stakeholders – providers, consumers, employers and brokers – change from a system that has historically focused on sick care to one that promotes optimal health. Anthem has taken this need for change head on by focusing on three strategic areas, which are the pillars of our proposed acquisition of Cigna: 1) a better consumer experience; 2) cost containment to improve affordability; and, 3) strong collaboration with providers.

My testimony today will focus on the following areas:

- *Value of an Anthem-Cigna Combination*
- *Complementary Nature of the Proposed Deal*
- *Marketplace Dynamics*
- *Federal and State Oversight of the Transaction*

Value of an Anthem-Cigna Combination to Consumers

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

Consumer engagement and data transparency

As health care evolves, consumers are demanding more information from a variety of trusted resources in

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

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

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

Improving quality and affordability

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

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

- Cigna Collaborative Care (CCC) is a value-based initiative that uses incentives to engage health care professionals and help drive improved health, affordability and patient experience. CCC represents an industry-leading 19 percent of total commercial contracts, and includes large primary care physician groups, hospitals, small primary care practices and specialist, including OB-GYN practices, among others. 82% of doctors and hospitals with two or more years of experience with CCC have had success in achieving their total medical cost targets and 72% had success in achieving their quality targets.

- With spending on cancer medication expected to increase by 50 percent through 2024, 25 percent growth in new cancer therapies that average an annual cost of $100,000 each, and one in three cancer patients receiving treatment that is not consistent with medical evidence or best practices, Anthem's Cancer Care Quality program – a joint collaboration with providers and oncologists that seeks to arm these experts with the information and tools they need to identify evidence-based care paths – has advanced better informed decision-making in cancer care and treatment. In its first year, 65 percent of members in the sample are already on a high-quality pathway.

- As part of Cigna's efforts in wellness programs, the City of Houston, Texas is the recipient of the Government Sector Well-Being Award for its dynamic and engaging wellness program, which includes completion of the annual health risk assessment with biometrics and participation in various activities including health education seminars, preventative care visits, and completion of coaching programs. The City has realized an estimated savings of $42 million in health care costs

over the last three years and lowered its average annual health care trend increase to 1.1%, down from 10%.

- Anthem's Imaging Cost and Quality program is proactively engaging consumers by educating them about lower cost, high quality alternative locations to receive care for certain procedures, like MRIs, which can save $220 per test, on average.

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

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

- Anthem, through our CareMore Health subsidiary, has demonstrated that by investing in care during the earlier stages of a beneficiary's illness or condition, and through strong collaboration with primary care physicians and bricks and mortar care centers, not only is the progression of illness slowed, but, when compared to traditional Medicare fee-for-service, overall health costs are reduced. For instance, through CareMore's unique and member-focused approach, its members with chronic kidney disease (CKD) progress to dialysis in slightly over 24 years, as opposed to less than six years for beneficiaries with CKD in fee-for-service. Also, through its disease management programs, CareMore has reduced stroke risk for its members by 40 percent and amputation rates for diabetics by 60 percent.

- At the same time, Cigna's HealthSpring subsidiary – in complementary locations across the country – partners with physicians to transition to alternative payment models. Almost two-thirds of Cigna-HealthSpring's members in HMOs receive care through physicians who are incentivized to deliver better outcomes and higher patient satisfaction. For instance, Cigna-HealthSpring members receive: 19 percent more colonoscopies, which lower the risks associated with colorectal cancer; 11 percent more mammograms, which lower the risks associated with breast cancer; and, six percent more diabetic cholesterol screenings, which lower the risks associated with heart attacks and stroke.

Provider collaboration and value-based reimbursement

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

In January 2015, the U.S. Department of Health and Human Services announced (during an event attended by Anthem's chief medical officer, Dr. Samuel Nussbaum) a historic timeline for shifting 50 percent of Medicare payments from fee-for-service to quality- and value-based through the adoption of alternative payment models by 2018. In addition, Congress, through passage of the Medicare and CHIP Reauthorization Act of 2015 earlier this year, reformed Medicare physician payment by setting a course for consolidating quality reporting requirements and creating a new reimbursement structure for physicians based on medical outcomes instead of the volume of services provided in the previous SGR methodology.

Anthem and Cigna are also committed to aligning incentives to encourage smarter, collaborative decision-making that fosters healthier outcomes and a better patient experience. More than $50 billion (53 percent) of Anthem's total health care reimbursement is tied to value-based contracts, with 150 accountable care organizations (ACOs), 787 hospitals, and 163,000 network physicians. In fact, through our new Enhanced Personal Health Care arrangement with participating providers – where the emphasis is on value-based payments rewarding high quality and efficiency, the exchange of clinical data, and a mutually-shared commitment to patient-centered care – Anthem is able to serve 4 million of our members. This focus has allowed us to get more care provided under the value-based umbrella – a number that will only grow as a result of the proposed deal, having a more immediate impact on our ability to bring down the total cost of care. Anthem also has a first-in-the-nation partnership with seven of the top 30 competing hospital systems in Los Angeles and Orange County, that enabled us to launch Vivity, an integrated health system that moves away from traditional fee-for-service and towards a structure that financially rewards activities that keep patients healthy, both simplifying access and making costs more predictable.

Eighty percent of Cigna-HealthSpring's Medicare Advantage membership is tied to value-based reimbursement. In addition, more than 35 percent of Cigna's total commercial health care reimbursement is being tied to value-based contracts, primarily through its Cigna Collaborative Care initiative, which

includes arrangements with 134 large physician group practices, more than 30 specialty groups, and over 80 additional arrangements covering more than 240 individual hospitals. Cigna Collaborative Care works to bridge the gaps in information and care by creating a model that rewards for quality outcomes and gives healthcare professionals the information – and the support – they need to achieve those outcomes. And the results speak for themselves:

- *Improved health* – with 3% better than- market average quality performance; 19%–25% better compliance rate with diabetes measures; and, 21% more gaps in care closed.

- *Lower cost* – with 3% better than- market average total medical cost; 52% conversion rate to lower cost medications; and, 4%–5% lower total medical cost trend versus peers.

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

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

Complementary Nature of the Proposed Deal

Health care is local – it is delivered and paid for locally, even when administrative functions are located elsewhere. To characterize Anthem and Cigna as two of five "national insurers" is inaccurate and an oversimplification of the role we play in the varied communities we serve across the country.

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

At Anthem, we look at the provision of small group as insurance plans for small employers with 2-50 employees; we have a presence in this segment in 14 states. Cigna does not market to this group.

Likewise for purchase of individual plans, where consumers obtain coverage directly for themselves, often through the exchange marketplace or a broker, Anthem, again, has a presence in 14 states. Cigna has a presence in 12 states. The combined company would only share a limited number of rating regions within just five states, where there is now and will continue to be robust competition. Underscoring this is the fact that consumers can now choose from an average of 40 health plans in states participating in the insurance exchange marketplace – an increase of 25 percent in 2015.[1] In local exchanges, consumers have an average of 23 different plan choices at the silver metal level. Further, new business models – CO-OPs like Colorado's HealthOP and venture capital backed companies like Oscar Healthcare – are entering this segment and expanding their coverage, along with provider-sponsored health plans and plans that traditionally have served other segments. HealthOP's success in Colorado is a model of how dynamic our industry is. Kaiser, a vertically integrated provider-based insurer, has long been the most significant individual insurer in the state. Within a year of entering, HealthOP has become the largest provider for individuals in Colorado, overtaking even Kaiser. The Silicon Valley-backed startup, Oscar provides yet another model of entry. Oscar is a new entrant that leverages technology and promises to offer a new way to purchase and use insurance. It is emblematic of the changing face of the competitive landscape in the insurance industry. With significant investment from companies like Google, Oscar has already signed up more than 40,000 people in New York and New Jersey, the first and only markets it has entered, with plans to expand to California and Texas in 2016.

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

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

In addition, employers often disaggregate or carve up health benefits into product segments (e.g. medical, dental, vision, pharmacy, life and disability, etc.) and issue separate RFPs, generally by geographic region, to ensure the most efficient use of their dollars.

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

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

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

regarded integrated behavioral, pharmacy, vision, dental, and other specialty products will expand options and enhance health. One hundred percent of the savings that result from Anthem and Cigna care management programs are passed through to large employers that self-insure.

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

For Medicare Advantage (the private plan alternative to Medicare fee-for-service), the total membership for the combined company would be minimal (a six percent share combined, according to a recent analysis by the Kaiser Family Foundation, which amounts to about one million covered lives for the combined organization). Anthem does business in 20 states, primarily in New York, Ohio, and California. Cigna, meanwhile, does business in 15 states and the District of Columbia, primarily in Florida, Tennessee, Pennsylvania, and Texas. The companies thus have a highly complementary geographic footprint. On average, all Medicare beneficiaries are able to choose from 18 Medicare Advantage plans in 2015.[2]

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

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

submitted bids, with four being awarded state-wide contracts, which means Medicaid beneficiaries will have four health plans from which to choose.

Other Notable Marketplace Dynamics

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

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

Federal and State Oversight of the Transaction

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

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

committed to working cooperatively with all relevant policymakers and regulatory entities.[4] We hope to close this transaction in the next 12-16 months. We have met with the Department of Justice and with the National Association of Insurance Commissioners, and have been engaged in our state filings. And, we are committed to remaining transparent throughout the entirety of this process about our plans with all of our stakeholders and interested parties.

Conclusion

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

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

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

Thank you.

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

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BEFORE THE U.S. SENATE
Committee on the Judiciary
Subcommittee on Antitrust, Competition Policy and Consumer Rights

Hearing on "Examining Consolidation in the Health Insurance Industry and its Impact on Consumers"

September 22, 2015

* The views expressed in this testimony are those of the author and do not necessarily represent the views of any of his organizational affiliations.

Chairman Lee, Ranking Member Klobuchar and members of the Subcommittee, thank you for the opportunity to testify on consolidation in the health insurance industry and possible consumer impact of the pending mergers of Anthem and Cigna and Aetna and Humana. I am the Norman Topping Chair in Medicine and Public Policy at the Sol Price School of Public Policy at the University of Southern California (USC). I also serve as Director of Public Policy at the USC Schaeffer Center for Health Policy and Economics. Previously, I founded and led the Center for Studying Health System Change (HSC) from 1995 to 2013. At HSC, we studied changes in the financing and delivery of health care and their impact on people, with a particular emphasis on understanding health care market dynamics. My goal today in testifying is to point out how the pending mergers of large national health insurers fit into ongoing and future changes in health care financing and delivery.

I will begin with brief comments about the complexity involved in analyzing health plan mergers. Then, I will provide some context about health insurance markets and the pending mergers with the caveat that the Department of Justice will conduct a detailed analysis of the possible effects of these mergers on competition. I raise a general point that governments affect the degree of competition among health care providers and insurers in many ways and analyzing these pending mergers should spur more attention to making policies more "pro-competitive." In the context of the risk of higher prices that could result from increases in insurance market concentration from these mergers, I sketch out possible upsides for consumers from the mergers for your consideration. Finally, in response to a Subcommittee staff request, I discuss how the Affordable Care Act (ACA) may have influenced health plan decisions to pursue mergers.

Perspectives on Insurance Mergers

Compared to mergers in other industries, health insurer mergers are particularly challenging to analyze because insurers play an intermediary role and compete in numerous distinct market segments. As intermediaries between healthcare providers and health care purchasers, insurers purchase medical services from a wide range of providers and sell insurance to cover these services to a wide range of customers, including employers, governments and individual consumers. Health plan mergers are likely to influence prices paid to providers, which in turn could affect premiums charged to purchasers. However, the competitiveness of insurance markets plays an important role in whether lower provider prices gained from insurer consolidation are passed on to purchasers of insurance.

Insurers also operate in numerous market segments that are distinct but related to each other in complex ways. Insurance markets are distinguished by the nature of the purchaser—individuals, small employers, large employers that purchase insured products and large employers that self-insure, or bear the financial risk for the cost of covered services, and purchase only administrative services. These administrative services typically include claims processing, access to provider networks, utilization management and specialized care management for

seriously ill patients with high medical costs. In addition, Medicare Advantage (MA), Medicare supplemental coverage and Medicaid managed care insurance markets are distinct.

With the exception of the market for large self-insured employers, these markets are distinct for geographic areas. In contrast, the market for the largest self-insured employers is national. The proposed mergers are likely to have more impact on certain market segments than others. In addition, some market segments tend to be much more competitive than others, with the national market for self-insured employers particularly competitive and the individual market historically less competitive, although the ACA appears to have increased competition in the individual market.

It is the job of the Department of Justice (DOJ) to conduct an in-depth analysis of the proposed mergers to assess the potential impact on competition and consumers. And, any DOJ approval is likely to be conditioned on specific divestitures in local markets where the merging firms both already have significant market share. While I do not have a position on whether these mergers should be approved or not, I do have a number of ideas about how Members of Congress—and the DOJ—might think about these mergers.

Effects on Competition

The effects of mergers in health care on prices and quality of care has received a great deal of attention from economists. Much of the research has focused on mergers among providers, especially hospitals, and clearly shows that hospital mergers have led to higher prices without measurable effects on quality.[1] Research is only beginning on the impact of hospital acquisition of physician practices on prices and quality, although early studies indicate that such acquisitions lead to higher prices.[2]

Less research has focused on insurer mergers, which are particularly complicated to study for the previously cited reasons. Several studies have shown that insurance mergers have led to lower prices paid to providers.[3] Fewer studies have looked at the impact of insurance mergers on prices for insurance. My fellow panelist Leemore Dafny conducted a well-known study of the late-1990s merger between Aetna and Prudential and found that higher insurance prices resulted.[4] In her article, she also explained how the Aetna-Prudential merger offered an exception from inherent difficulties in studying the impact of insurer mergers with time series

[1] Gaynor, M., and R. Town, *The Impact of Hospital Consolidation – Update*, Robert Wood Johnson Foundation Synthesis Report (June 2012).
[2] Baker, L. C., M.K Bundorf and D.P. Kessler, "Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending," *Health Affairs*, Vol. 35, No 5 (May 2014).
[3] Melnick, G., Y. Shen and V. Wu, "The Increased Concentration of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices," *Health Affairs*, Vol. 30, No. 9 (September 2011).
[4] Dafny, L., M. Duggan and S. Ramanarayanan, "Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry." *American Economic Review*, Vol. 102, No. 2 (April 2012).

data. A recent study by Trish and Herring, using cross-sectional data for 2011, found that more concentrated insurer markets led to lower prices paid to providers, but savings were not passed on to insurance purchasers in the form of lower premiums. Instead, the study found that lower prices paid to providers and higher margins on insurance products roughly offset one another.[5] But a result with particular relevance to the Anthem-Cigna merger is that self-insured employers got lower prices for health benefits in areas where insurer concentration was higher.

The two mergers being discussed today appear to have less in the way of significant increases in concentration in market segments than other mergers among large insurers, such as the Aetna-Prudential merger in the late-1990s. Potentially problematic impacts of the Aetna-Humana merger appear mostly in the Medicare Advantage market, where some local markets would become substantially more concentrated. These impacts can be addressed through divestitures. Medicare Advantage stands out from other insurance markets in a number of ways. Since these plans are alternatives to traditional Medicare, some beneficiaries will respond to any resulting price increases by returning to traditional Medicare. The structure of the MA market and regulations governing it mean that mergers will not lead to lower hospital prices, which are indirectly linked to payment rates in the traditional program.[6] Finally, the federal government controls how much it pays to MA plans, so mergers do not pose a specific risk to federal outlays, in contrast to the public exchange environment. This does not mean that increased concentration in MA should not be taken seriously; the program is highly concentrated and more concentration likely would lead beneficiaries to pay higher premiums or receive less in the way of additional benefits.[7]

Turning to the Anthem-Cigna merger, the most significant area where concentration would increase is in the national market for large self-insured employers. Increased concentration in that market might have less impact than in other market segments because of the sophistication of the purchasers, who are human resource executives in large companies. Wall Street analysts indicate that this market tends to be highly competitive and that profit margins on the administrative fees charged to large employers are relatively low. Thus, even a substantial increase in these margins would not have a large percentage impact on what large employers pay for coverage. Note that the Trish and Herring study referenced previously found that increased insurer concentration led to lower payments for large self-insured employers, although that is only one study.

Antitrust policy is not the only public policy that affects the degree of competition in health care markets. In some cases, concentrated health care markets can be made substantially more

[5] Trish, E.E., and B.J. Herring, "How Do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums?" *Journal of Health Economics,* Vol. 42 (July 2015).
[6] Berenson, R., et al., "Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices," Health Affairs, Vol. 34, No. 8, (August 2015).
[7] Biles, B., G. Casillas and S. Guterman, *Competition Among Medicare's Private Health Plans: Does It Really Exist?,* The Commonwealth Fund, New York, N.Y. (August 2015)

competitive. Take for example, the bidding process for Medicare Advantage. Instead of setting the benchmark that determines the Medicare payment on the basis of experience in the traditional Medicare program, a process that sets the benchmark on the basis of health plan bids would likely make MA markets more competitive and lead to savings for the Medicare program.

Another example of policies that can make markets more competitive is from provider markets. The publicly run insurance exchanges created by the ACA have proved fertile ground for health plans to offer products with limited-provider networks. These products typically have premiums about 15 percent lower than comparable plans with broader provider networks, some savings coming from excluding high-price providers and some from providers negotiating lower rates to be included in the limited network.[8] The design of the exchanges was a factor in these products gaining substantial enrollment, but policies on network adequacy, now under development in states and led by the National Association of Insurance Commissioners, could inadvertently limit this tool.[9]

Some trends only indirectly related to policy are increasing the competitiveness of health insurance markets. Some large health care systems are entering the insurance business, either by creating an insurance subsidiary or through joint ventures with existing insurers. Often the insurance products sold have limited- or tiered-provider networks, with the sponsoring or partnering health system in a favored position. A recent Avalere Health analysis reports that 15 of the 28 new entrants into MA between 2012 and 2015 are health systems and 37 provider sponsored plans offer coverage on public exchanges.[10] Individual insurance markets under the ACA have seen substantial entry by new insurers or existing insurers entering selected geographic markets.[11] The recent development of private exchanges, which are being adopted by many employers to give employees a wider choice of health plans, will also likely make the health insurance market more competitive. They have gotten off to a fast start and could play a large role in the employer market in the future.

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[8] Bauman, N., et al., *Hospital Networks: Evolution of the Configurations on the 2015 Exchanges,* McKinsey Center for U.S. Reform (April 2015).

[9] Since those shopping for insurance on the exchanges pay out of pocket the full difference in premiums among plans, even those who are subsidized, consumers are highly sensitive to premium difference. In addition, since plans are chosen by individuals rather than for groups, the typical "one-size-fits-all" constraint in employer-based coverage does not apply.

[10] *New Market Entrants: Growth and Diversification in U.S. Health Insurance,* Avalere Health (September 2015).

[11] Oatman, J.E., P. Finn and E.H. Coe, *The Emerging Story on New Entrants to the Individual Health Insurance Exchanges,* McKinsey & Company (September 2015).

A National Academy of Social Insurance panel of experts—which I served on—recently published a report exploring numerous opportunities for governments at the federal and state level to take steps to lower health care prices through policies to increase competition.[12]

Potential Upside from Mergers

Insurance mergers do pose risks that purchasers of insurance will pay higher prices for coverage. Policymakers' willingness to accept these risks will depend in part on whether they believe the mergers have sufficient potential to improve health care delivery. Wall Street analysts believe that these mergers will lead to substantial administrative cost reductions for the insurers. One firm estimates that by the second year of an Anthem-Cigna merger, "synergies" will reduce operating costs for Cigna by 20 percent.[13] Savings might be achieved in information technology, network negotiation, regulatory compliance and other areas. These are true efficiencies from scale economies, but it is uncertain what portion would be captured by shareholders and what portion passed on to insurance purchasers.

Health plan mergers are likely to facilitate movement to alternative payment models for providers. Plans with a large number of enrollees in a market are likely to be more attractive contracting partners for providers. Not only will the potential upside of such a relationship be larger in relation to the provider management resources that would have to be devoted to the relationship, but the risk to providers of investing to change delivery in ways that increase value while still having a large part of revenues come from traditional fee-for-service payment would be diminished. When I interview hospital and physician leaders, they often use analogies like "one foot in the boat and the other on the dock" to explain a key challenge they face in transitioning from traditional payment mechanisms to value payment mechanisms such as global budgets, accountable care organizations, bundled payment and patient-centered medical homes. The ability to pursue these changes with Medicare, Medicaid and one or more large insurers makes the transition more feasible. From the health plan perspective, mergers could make it more feasible to devote resources to develop contracting approaches and the essential real-time feeds of claims data to providers that are needed for these payment approaches to succeed.

In recent years, insurers have invested in using claims data in real time to identify enrollees undergoing treatment for potentially expensive conditions where additional care management can lead to better outcomes and lower costs. For example, care coordination can be offered to patients seeing numerous physicians. Or accommodations can be made to allow some patients to recuperate at home rather than in a skilled nursing facility. Mergers allow economies of scale to spread the fixed costs of developing the analytics to support these interventions.

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[12] National Academy of Social Insurance, *Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Market,* Washington, D.C. (April 2015).

[13] Goldman Sachs, *Updating Pro Forma Analysis Following ANTM-CI Merger Agreement* (July 28, 2015).

More controversial is the potential for mergers to lower provider prices. Providers are arguing against insurer mergers because the potential for lower prices is real. But international comparisons of health spending suggest that higher prices are the key reason why the United States spends so much more for health services as a percentage of GDP than other advanced countries.[14] Of course, lower prices will benefit the public only if they are passed through to insurance purchasers in the form of lower premiums.

The Affordable Care Act and Insurance Mergers

The ACA likely has played a role in the mergers being considered today, some of which should be seen in a positive light. The impact of the most controversial portions of the ACA—tax credits to purchase private insurance on public exchanges and Medicaid expansions—are likely not major factors behind these mergers. As discussed previously, the key focus of the two mergers being discussed today is the market for self-insured plans for large employers and the Medicare Advantage market.

In contrast to promoting mergers, tax credits to purchase private insurance on public exchanges expanded the market for individually purchased insurance and made that market more competitive. As a result of the exchanges, this market is easier to enter; there has been entry of both new insurers and existing insurers that had not entered this market in the past. It also has made it easier for health plans sponsored by large health care systems to get a foothold in insurance markets.

One ACA provision that stands out is the floor on medical loss ratios (MLR). This limits the percentage of the premium dollar that can go for expenses other than what is paid to providers on claims. My understanding is that the MLR regulations are binding in many market segments but not in others. Analysis of the two mergers that this hearing is focusing on suggests a potential to reduce administrative costs, potentially easing the challenge of complying with the MLR regulation without incurring losses. Opportunities to reduce administrative costs have become a higher priority to pursue.

Somewhat along the same lines, cuts in Medicare Advantage payment rates likely have increased pressure on insurers in this market to become more efficient. Motivated by a concern that Medicare was paying more for beneficiaries in the MA program than for those in the traditional Medicare program, cuts began before enactment of the ACA, but the law pushed the cuts further. So if merging MA businesses across two carriers can reduce costs through scale economies, the cuts in payment rates would be seen as a catalyst for a merger.

A potentially important ACA influence on mergers is Medicare provisions that have led to very extensive experimentation with alternative payment models. The ACA authorized Medicare

[14] McKinsey Global Institute, *Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More* (December 2008).

Shared Savings Programs for accountable care organizations and established a Center for Medicare and Medicaid Innovation with authority and funding to pilot innovations, many in the area of alternative payment. The Congress showed broad bipartisan interest in alternative payment models in Medicare when it passed the Medicare Access and Chip Reauthorization Act of 2015 (MACRA) by substantial margins. A key MACRA provision offers higher payment rates for physicians who are sufficiently involved with alternative payment models. With Medicare aggressively pursuing alternative payment models, this may help serve as a catalyst for private insurers to ramp up their efforts in this area. As discussed previously, mergers have the potential to facilitate private insurer efforts in this area.

Two other ACA provisions may be contributing to private insurer activity to promote alternative payment models. The ACA's reduction in future hospital payment rates for Medicare patients appears to have contributed to hospitals' interests in alternative payment models. With strong constraints on payment rates for admissions, broader payment units provide additional opportunities to be rewarded for cost reduction. It reminds me of hospital support in 1983 for the rapid transition from a system of cost reimbursement with increasingly restrictive limits on what could be reimbursed to the inpatient prospective payment system, where per case payments offered rewards to hospitals with lower costs per admission, such as through lower lengths of stay.

The so-called Cadillac tax provision—a 40 percent excise tax on high-cost health benefits—which is getting so much attention today, has increased employer attention to keeping the cost of their health benefits down. While employers are taking a wide variety of steps, including increasing deductibles and experimenting with private exchanges, one of the areas of interest has been shifting provider payment to emphasize value.

Conclusion

In summary, health insurance mergers in general are complex and difficult to analyze, particularly because of the intermediary role that these companies play between providers of health care and purchasers of insurance. The risks that consumers will pay more for coverage as a result of mergers are real, which makes a Department of Justice analysis of the proposed mergers and what conditions to impose so important. The two mergers being discussed at this hearing have a mix of market segments in which little increase in concentration is likely to occur, while others do raise concerns. The mergers have some potential upsides through reduced administrative costs and possible acceleration of alternative payment, but it is important to ensure that some of the potential upside will be passed on to purchasers of insurance and ultimately consumers. And while some ACA provisions may have contributed to insurers' interest in merging, many should be seen in a positive light.

TESTIMONY OF LEEMORE S. DAFNY, Ph.D

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Before the

Senate Committee on the Judiciary

Subcommittee on Antitrust, Competition Policy, and Consumer Rights

On

"Health Insurance Industry Consolidation:
What Do We Know From the Past, Is It Relevant in Light of the ACA, and
What Should We Ask?"

September 22, 2015

Summary

Nearly two-thirds of the U.S. population under age 65 is enrolled in a private, comprehensive health insurance plan.[1] The private health insurance industry is also playing an increasingly important role in supplying coverage to enrollees in public insurance programs. The public interest in a competitive, robust marketplace has never been greater. Not only are private insurance premiums ($16,834 for the average family) and out of pocket spending ($800 per person)[2] high and projected to grow, but the individual health insurance mandate now requires those without public coverage to purchase private policies. Federal subsidies for the purchase of private insurance through the health insurance marketplaces are projected to total $32 billion in 2015, and $84 billion by 2020.[3] Given these stakes, there is a substantial public benefit to critically evaluating any significant changes in industry market structure.

There are two primary and complementary ways to assess the impact of consolidation: backward-looking (what has happened in the past?) and forward-looking (what is different, if anything, and how might those differences alter predictions based on the past?). This testimony addresses both. First, I review economic studies on the impact of insurance consolidation on premiums and other outcomes of potential interest to consumers. These studies suggest that consolidation leads to premium increases. This is true notwithstanding the growing body of research that finds insurers with larger local market shares pay lower rates to healthcare providers, particularly hospitals.[4] As I discuss below, lower provider rates can, under certain circumstances, also harm consumers directly. The evidence on the link between insurance market concentration and health plan quality is sparse, but at least one study suggests benefit generosity declines with fewer competitors.[5]

In sum, economic research demonstrates that insurance industry consolidation in the past has not tended to improve the lot of consumers. Any individual proposed merger may have different

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[1] National Center for Health Statistics, "Early Release of Selected Estimates Based on Data From the National Health Interview Survey, 2014," Table 1.2b, *available at* http://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201506.pdf.
[2] 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.
[3] Congressional Budget Office, *Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline*, March 2015, *available at* https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf.
[4] I discuss the evidence on this point below.
[5] Robert Town and Su Liu, "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* (2003): 719-736.

effects and should be evaluated on its own potential merits, however these merits should be assessed with the context provided by this academic, refereed body of literature.[6]

Proponents of continued industry consolidation have introduced two primary arguments for why the existing research is not prescriptive in the post-ACA era. The first is that the Medical Loss Ratio (MLR) regulation[7] prevents merging insurers from reaping profits that might otherwise be possible as a result of a post-merger increase in market power. Essentially, this amounts to a claim that the MLR regulation provides a substitute for competition. There are a number of reasons to doubt this supposition. Chief among them: the MLR regulation does not pertain to the majority of privately-insured Americans, who are enrolled in self-insured plans (which are exempt from the regulation)[8]; it does not adequately address non-price competition; it is likely "gameable"; and the legislated minima may be below prevailing MLRs in certain markets and have no impact at all.

The second argument is subtle, and embraced to a greater extent by economists than industry: insurers with larger local market share have stronger incentive to invest in changing the healthcare delivery system through payment innovations because they can reap more of the rewards from their local investments. At the same time, providers can spread their costs of collaborating on these innovations across more lives. Although this argument has merit, there is also an important countervailing effect of size. An insurer with stronger market power has less of an incentive to invest in new products as it "replaces itself" in the market, i.e. there is less potential to "steal business" from rivals. In addition, there is no research showing that larger insurers are likelier to innovate.

In sum, I see no reason the evidence from the past should be discounted when evaluating current and future consolidation. I would also caution that consolidation that occurs now is unlikely to be undone if it later proves anticompetitive. History also suggests that vigorous competition by new entrants is unlikely to arise and offset such effects.

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[6] As the Horizontal Merger Guidelines state, merger analysis "is a fact-specific process." U.S. Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines*, 2010, *available at* http://www.ftc.gov/os/2010/08/100819hmg.pdf.

[7] The ACA requires health insurers to maintain an MLR, defined as the proportion of premium revenues spent on clinical services and quality improvement, above 80% for fully-insured individual and small group plans and 85% for fully-insured large group plans. An insurer falling short of these minima must provide rebates to policyholders such that the MLR meets the prescribed level. *See*, e.g., Center for Consumer Information & Insurance Oversight, "Medical Loss Ratio: Getting Your Money's Worth on Health Insurance," Dec. 2, 2011, *available at* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/mlrfinalrule.html.

[8] Approximately 54% of privately insured Americans are exempt from MLR requirements. (This figure is derived as the product of the share of privately insured Americans with employer-sponsored coverage–88 percent–and the share of covered workers enrolled a plan that is completely or partially self-funded–61 percent.) 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. Kaiser Family Foundation, "Health Insurance Coverage of the Total Population," 2015, *accessed* Sep. 9, 2015, http://kff.org/other/state-indicator/total-population.

My testimony concludes with a call for sunshine. It is unlikely that consolidation is "inherently bad" or "inherently good"; we need research that reveals how to protect against harms and unlock benefits. Current and historical data on various aspects of commercial health insurance (e.g., enrollment and costs) at a disaggregated level (e.g., by specific health plan, customer segment, and sub-state geographic market, such as the MSA) would enable research that would help us to understand whether and where consolidation is harmful or beneficial, and for whom. While such transparency is rare in many private industries, it is common where there is a strong public interest and substantial public regulation, both of which characterize this vital sector.

1. Concentration in the Health Insurance Industry Is High and Growing

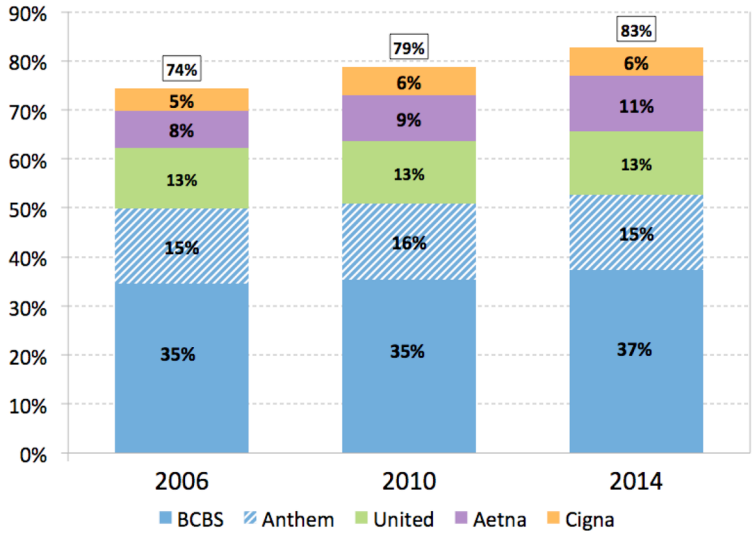
1.1 Private Health Insurance Plans

Roughly 175 million Americans under age 65 purchased private insurance through their employers or via the individual insurance market in 2013, the most recent year for which data are available.[9] The industry has expanded since the introduction of the health insurance marketplaces in 2014.

Figure 1 contains my rough estimates of the national market share of the four largest insurers over the period 2006–2014. For most customers – national multisite employers being the primary exception – insurance markets are local, but these share estimates provide context for the changing landscape. In the figure, all 36 Blue Cross and Blue Shield (BCBS) companies are grouped together. With a few exceptions, BCBS affiliates have exclusive, non-overlapping market territories, and hence do not compete with one another. Shares for Anthem, Inc., the for-profit insurer (previously known as Wellpoint) that today operates BCBS plans in 14 states, are denoted separately.

[9] Per the U.S. Census Bureau's 2013 Current Population Survey (CPS) Annual Social and Economic (ASEC) Supplement, Table HI01, *available at* https://www.census.gov/hhes/www/cpstables/032014/health/h01R_000.htm.

Figure 1. Estimated National Market Shares of 4 Largest Insurers, 2002–2014[10]



The national four-firm concentration ratio (the sum of the leading four firms in terms of market share) for the sale of private insurance increased significantly between 2006 and 2014, from 74 to 83 percent. As a point of comparison, the four-firm concentration ratio for airlines is 62 percent.[11] BCBS affiliates collectively account for over half of privately-insured lives today, a position they have held throughout this period (following growth during the first half of the 2000s, not pictured). The figure also reflects some of the more significant mergers among non-BCBS insurers in recent history, including the acquisition of Coventry by Aetna (in 2013).

[10] Figure 1 is constructed using the number of privately-insured lives reported in each insurer's annual reports. Consistency over time and across insurers in terms of products included is not assured. BCBS share (exclusive of Anthem) is estimated using enrollments reported by BCBS for 2010 and 2014, and extrapolating back to 2006 by applying the growth rate in BCBS enrollments from data supplied by the National Association of Insurance Commissioners (NAIC), and corrected for states not reporting or underreporting BCBS enrollment. The BCBS association reports total enrollment of 100 million in 2010 and 106 million in 2014 and may include non-comprehensive insurance. Unfortunately, NAIC reflects only fully-insured plans outside of California, whereas Figure 1 includes both full and self-insurance for all states. Anthem operates BCBS affiliates in CO, CT, KY, ME, NH, NV, OH, VA, IN, GA, MI, WA, CA, and NY. National market size in each year is the number of privately-insured lives, as estimated from the Current Population Survey. Current Population Survey, "Total people with private health insurance," 2002–2013, *available at* http://www.census.gov/cps/data/cpstablecreator.html.

[11] U.S. Department of Transportation Bureau of Transportation Statistics, "Airline Domestic Market Share July 2014–June 2015," *available at* http://www.transtats.bts.gov/.

Figure 1 does not necessarily reflect the degree of concentration in insurance markets that are relevant to most consumers. Commercial health plans are generally offered and priced differently for each customer segment (e.g., individual, small group, large group-fully insured, large group-self-insured – and perhaps others) in different geographic areas. These areas are generally smaller than the state (e.g., metropolitan and/or micropolitan statistical areas or ratings areas as defined for the state health insurance marketplaces).[12] There are many health plans with a significant local, but not a national, presence - Kaiser, Intermountain, and Geisinger among them. The degree of competition in any product and geographic market depends on the relevant market participants (current and potential), and on the characteristics of the plans they offer (or might offer).

The American Medical Association publishes an annual report containing commercial insurance market shares for the top 2 insurers, as well as corresponding market Herfindahl index (HHI), in 388 metropolitan statistical areas (MSAs). These reports show that concentration is generally higher within local markets than in the nation as a whole: the median population-weighted *two*-firm concentration ratio for 2012 is 0.65. Concentration within MSAs also appears[13] to be increasing over time. The median HHI increased from 1,716 in 2001 to 2,973 in 2012, well in excess of the threshold for "highly concentrated" (2,500) per the *Horizontal Merger Guidelines* issued jointly by the Department of Justice and the Federal Trade Commission.[14]

1.2 Medicare Advantage

There are nearly 22 million Medicare beneficiaries enrolled in Medicare Advantage plans of various kinds.

Figure 2 presents the market shares of the four leading providers of Medicare Advantage plans in from 2007 to 2015. Again, these shares are provided for context and may not reflect market structure at the local level at which Medicare beneficiaries make plan selections. The four-firm concentration ratio increased markedly between 2011 and 2015, rising from 48 to 61 percent. The Medicare Advantage market has experienced significantly more turbulence than the private insurance sector, owing to myriad changes in regulations and reimbursement rules.[15] The

[12] For example, plans offered on the Health Insurance Marketplaces are priced at the rating area level. Rating areas are defined as one or more counties and are generally smaller than MSAs. *See, e.g.,* Kaiser Family Foundation, "Medicare Advantage," Jun. 29, 2015, *accessed* Sep. 9, 2015, http://kff.org/medicare/fact-sheet/medicare-advantage. CMS Center for Consumer Information and Consumer Oversight, "Market Rating Reforms," May 28, 2014, *accessed* Sep. 9, 2015, https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/state-gra.html.

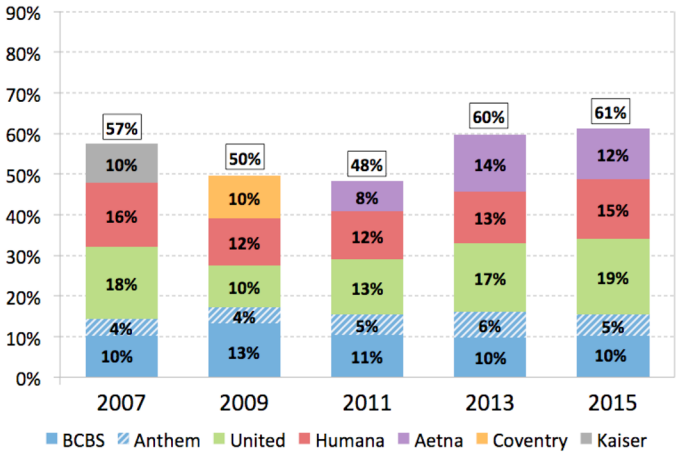
[13] The AMA reports are not strictly comparable over time due to changes in the number of MSAs included, and the inclusion of self-insured lives. The figures for 2012 include self-insured lives.

[14] U.S. Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines*, 2010, *available at* http://www.ftc.gov/os/2010/08/100819hmg.pdf.

[15] Total enrollment in Medicare Advantage has increased significantly over this period, from 9.3 million in 2007 to 22 million in 2015. Duggan, Starc and Vabson (2014) show that reimbursement is strongly linked to entry. They

national market leaders for Medicare Advantage are a bit different from those in the private insurance market (in Figure 1), although they are the same as the market leaders in the fully-insured segment of private insurance.[16]

Figure 2. Medicare Advantage 4-firm Concentration Ratio, 2007–2015[17]



Most of the research on insurance consolidation utilizes data from private insurance plans, hence my testimony focuses on this set of customers. Although Medicare Advantage and other health insurance products such as Medicaid Managed Care plans are clearly different – e.g., they face different regulatory requirements, and different challenges with regard to assembling provider networks and negotiating competitive provider rates – the insights from private insurance markets are clearly relevant in light of the similarities in the "production process" for insurance, as evidenced by the significant overlap in the suppliers across the different market types.

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estimate that for every dollar of additional reimbursement from the Medicare program, 20 cents is passed through to enrollees in the form of better coverage. Mark Duggan, Amanda Starc, and Boris Vabson, "Who Benefits When the Government Pays More? Pass-through in the Medicare Advantage Program," No. w19989, National Bureau of Economic Research, 2014.

[16] In 2013, these are United (14 percent), Anthem (11 percent), Aetna (7 percent) and Humana (4 percent). Source: 2013 CCIIO MLR data, *available at* https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.

[17] Source: Centers for Medicare and Medicaid Services, Medicare Advantage Enrollment Data, 2007–2015, *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html.

1.3 Drivers of Industry Consolidation

Industry consolidation arises from two sources: structural (i.e., entry, exit, and mergers), and non-structural (i.e., growth or decline of incumbent firms). There is little research on the relative contribution of each to rising concentration.[18] Most of the structural change has been driven by mergers, and the most significant non-structural development appears to be the growth in the market shares of the various BCBS affiliates.[19]

Insurance mergers over the past 20 years can be characterized by four phenomena: (1) attempts by regional insurers to gain broader service areas; (2) attempts by national insurers to obtain a presence in virtually all geographies; (3) acquisitions of local HMOs and provider-sponsored plans by incumbents; (4) consolidation of for-profit BCBS affiliates (into Anthem). Reported motivations include a desire to achieve economies of scale in administration, sales, and marketing; to achieve economies of scale (more lives) and scope (more product lines) with respect to pioneering novel care management and shared savings programs; to strengthen the insurer's negotiating position vis a vis providers (who are themselves growing more concentrated); and to diversify across revenue sources (e.g., government and non-government-insured lives). It is possible that the most recent merger wave is a "contagion" ignited by the announcement of some large acquisitions; to the extent that an insurer is contemplating a merger, learning of other suitors is a motivator to act quickly.

Some have posited that recent or proposed insurance mergers are the result of the Affordable Care Act (ACA). However, the figures above reveal consolidation was well underway before the ACA was passed. It is worth noting that, to the extent such consolidation is anticompetitive, it is at cross-purposes with the Act. As Professor Thomas Greaney recently observed in testimony before the House Subcommittee on Regulatory Reform, Commercial and Antitrust Law, the ACA "does not regulate prices for commercial health insurance or prices in the hospital, physician, pharmaceutical, or medical device markets. Instead the law relies on (1) competitive bargaining *between* payers and providers and (2) rivalry *within* each sector to drive price and quality to levels that best serve the public."[20]

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[18] Scanlon et al. (2005) find that non-structural fluctuations in enrollment accounted for more than one-third of the change in MSA-level HHI between 1998 and 2002. Scanlon, Chernew, Swaminatham, and Lee, "Competition in Health Insurance Markets: Limitations of Current Measures for Policy Analysis," *Medical Care Research and Review*, Vol. 63 No. 6, (Supplement to December 2006) 37S-55S. The insurer HHI data pertain only to HMOs.

[19] This growth precedes the period depicted in Figure 1. Per Ginsburg (2005), "the relative position of the Blues strengthened with the loosening of managed care because of the diminishing importance of HMOs, which were generally a weak point for the Blues. Blue plans' ability to negotiate lower rates with providers on the basis of their large market share became more important." Paul Ginsburg, "Competition in Health Care: Its Evolution Over the Past Decade," *Health Affairs* 24.6 (2005): 1512–1522.

[20] 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

In fact, the Act *promotes* competition in the insurance industry in several ways, including via regulatory reforms (e.g., product standardization and plan certification, which reduce the hurdle to entry posed by the need to establish a credible reputation) and via the health insurance marketplaces (which reduce marketing and sales costs, thereby raising the likelihood of entry). The Health Insurance Marketplaces were explicitly designed to facilitate competition among insurers. The notion that the ACA's MLR regulations, which place a floor on the share of premiums devoted to medical spending and quality improvement activities, provoke consolidation is inconsistent with profit-maximizing behavior. To the extent that scale reduces administrative costs, insurers would have benefited from such reductions in the absence of the regulation.

Even if the ACA *inadvertently* provoked consolidation – perhaps because of a surge of investor interest in growing private insurance markets, and the thirst for higher company valuations – the question before the committee today is whether this phenomenon is likely to be beneficial to consumers. To answer it, I begin by summarizing the empirical evidence on the effects of insurance consolidation.

2. What have we learned from the past?

2.1 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.

2.1.1 Effects of consolidation on healthcare provider prices and health plan quality

Several health economists have studied the correlation between insurance market structure, typically measured by insurer HHI at the MSA level, and hospital prices.[21] Using different data sources and time periods, these studies generally find hospital prices are lower in areas with higher insurance HHIs (typically measured at the MSA level). This relationship also holds when

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Judiciary, Subcommittee on Regulatory Reform, Commercial and Antitrust Law, Sep. 10, 2015, *available at* http://judiciary.house.gov/_cache/files/0a0e88c8-0519-4a47-8fa8-4c2233c760c3/greaney-testimony.pdf.

[21] Glenn A. Melnick et al., "The Increased Concentration of Health Plan Markets Can Benefit Consumers through Lower Hospital Prices," *Health Affairs*, 30, no. 9 (2011): 1728–1733; Asako S. Moriya, William B. Vogt, and Martin Gaynor, "Hospital Prices and Market Structure in the Hospital and Insurance Industries." *Health Economics, Policy and Law* 5.04 (2010): 459-479.; and Erin E. Trish, and Bradley J. Herring, "How do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums?" *Journal of Health Economics,* 42 (2015): 104-114. All three rely on estimates of insurer HHI calculated from InterStudy data. Melnick et al. find that hospital prices in 2001–2004 are lower in MSAs with higher insurer HHI, provided the insurer HHI exceeds 3,200. Moriya et al. find that increases in MSA-level insurer HHI between 2001 and 2003 are associated with decreases in hospital prices. Trish and Herring use more recent data (from 2006–2011) and find that hospital prices are lower among more concentrated insurance markets.

researchers study *changes* over time, i.e., areas experiencing faster growth in insurer HHI exhibit slower growth in hospital prices.

Lower prices for healthcare services will only benefit consumers if – and only if – they are ultimately passed through to consumers in the form of lower insurance premiums (and/or out-of-pocket charges); I discuss the lack of evidence for this pass-through below. However, it is worth noting that even if price reductions are in fact realized *and* passed through, if they are achieved as a result of monopsonization of healthcare service markets then consumers may experience an offsetting harm. Monopsony is the mirror image of monopoly; lower input prices are achieved by reducing the quantity or quality of services below the level that is socially optimal. [22]

There are a handful of studies that directly study monopsony. One study (of which I am a coauthor) finds such evidence in the wake of the Aetna and Prudential merger of 1999.[23] Post-acquisition, the combined entity covered 21 million lives. In the three-year period following the merger, we found relative reduction in healthcare employment and wages in those geographic areas where the two parties had more substantial pre-merger overlap. The implication is that the exercise of market power vis-a-vis healthcare providers reduced price *and* output – the hallmark of monopsony. Indeed, the DOJ had required Aetna and Prudential to divest health plans in two Texas markets before closing precisely because of concerns over post-merger monopsony power. This remedy proved effective: we found no evidence of monopsony in these markets following the merger.[24]

Whether monopsony is likely in the face of consolidation depends on the provider market in question. The textbook monopsony scenario described above pertains when there is a large buyer and fragmented suppliers, as is the case for physicians in some specialties within a given geographic area negotiating with dominant insurers. However, in settings where both sides possess market power and they bargain over prices, an increase in buyer power can reduce price without reducing output (or, equivalently, without leading to a deterioration in quality). Indeed, two other studies of monopsony focus on hospitals – an industry that is concentrated in many

[22] The way in which a monopsonistic insurance sector would achieve lower reimbursement rates is by setting a low market reimbursement rate, one which is beneath the value that some consumers place on those services. That is, there will be excess demand by consumers for services at this rate, and the monopsonist does not allow price to rise to expand output and equilibrate demand and supply.

[23] Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, "Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry," American Economic Review, 2012, 102(2): 1161–1185.

[24] The formal complaint alleged the merger "would enable Aetna to exercise monopsony power against physicians, allowing Aetna to depress physicians' reimbursement rates in Houston and Dallas, likely leading to a reduction in quantity or degradation in quality of physicians' services". U.S. vs. Aetna Inc. (ND TX, 21 June 1999)

areas – and they find areas with higher insurer HHI have higher, not lower, hospital utilization.[25,26]

In sum, there is some empirical evidence that consumers may be harmed as a result of lower payments to healthcare *personnel,* however more research is needed on this subject.

There is very little published research on the link between consolidation and plan quality. The most relevant study to date pertains to the Medicare Advantage market. The study found that the availability of prescription drug benefits (before the enactment of Part D) was higher in areas with more rivals, all else equal.[27] There is a vast literature in other healthcare settings – e.g., hospitals – showing that quality does not improve when markets become more consolidated.[28] Although quality is often more difficult to evaluate than price, the competitive mechanisms linking diminished competition to higher prices operate similarly with respect to lower quality.

2.1.2 Insurance Premiums

There are a number of studies documenting lower insurance premiums in areas with more insurers, including on the state health insurance marketplaces,[29] the large group market (self- and fully-insured combined),[30] and Medicare Advantage.[31] A recent study suggests premiums for employer-sponsored fully-insured plans are increasing more quickly in areas where insurance market concentration is rising, controlling for other area characteristics such as the hospital market concentration.[32]

Arguably the most relevant research in light of the recent proposed mergers are two studies of consummated mergers. Both found that structural changes in market concentration led to higher insurance premiums. The first is the previously-mentioned study of the Aetna-Prudential merger

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[25] Feldman and Wholey (2001) present evidence that prices are lower, but hospital utilization (a measure of quantity) is higher in markets with less competitive insurance markets. Similarly, McKellar et al. (2014) find in more concentrated insurer markets, health care prices are lower, utilization is higher, but overall spending is lower.
[26] It is worth noting that many health policy experts believe some types of health care services are overutilized. Where true, a quantity reduction arising from the exercise of monopsony power might be viewed as beneficial. However, this paternalistic approach to consumption is not ordinarily adopted by antitrust enforcers.
[27] Robert Town and Su Liu, "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* (2003): 719-736.
[28] See, for example, Gaynor, M. and R. Town (2012), "The Impact of Hospital Consolidation," *available at* http://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html
[29] Steven Sheingold et al., ASPE Issue Brief, "Competition and Choice in the Health Insurance Marketplaces, 2014-2015: Impact on Premiums," U.S. Dept. of Health and Human Services, July 27, 2015, *available at* http://aspe.hhs.gov/basic-report/competition-and-choice-health-insurance-marketplaces-2014-2015-impact-premiums.
[30] Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan. *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*. No. w15434. National Bureau of Economic Research, 2009.
[31] Zirui Song, Mary Beth Landrum, and Michael E. Chernew, "Competitive Bidding in Medicare: Who Benefits From Competition?" *The American Journal of Managed Care* 18.9 (2012): 546.
[32] Trish and Herring (2015). *Ibid.*

of 1999. Using detailed data on health insurance plans sponsored by large, mostly multi-site employers representing roughly 10 million lives, my coauthors and I found that premiums increased significantly more in areas with greater pre-merger overlap. Importantly, we were able to control for changes over time in the average premium for any given employer, so that these changes reflect relative differences across markets for the same firm. Moreover, premium increases were observed not just for the merging firms but for their rivals (in areas where the merging firms had substantial overlap). Thus, even though this particular merger was linked to lower healthcare personnel wages and employment, the cost savings were not passed on to consumers.

We used the estimate from the above paper to predict the impact of all (structural and non-structural) consolidation over the period 1998-2006. We estimate that large group premiums in 2007 were 7 percent (roughly $200 per person) higher than they would have been had local market concentration remained at its initial level. Although this is a small figure relative to the aggregate premium increase during the same period, it is large compared to typical operating margins of insurers – implying substantial consolidation-induced growth in profits.

A second study, Guardado et al. (2013), examined the effect of the 2008 merger between Sierra Health Services and United on small group premiums in two Nevada markets. As compared to control cities in the South and West, small group premiums in these markets increased by 13.7 percent the year following the merger.[33]

2.2 There are substantial barriers to entry in the private health insurance industry, and consolidation-induced premium increases have not generally been offset by competition from new entrants.

Over the past few decades, the private health insurance industry has seen relatively little entry by new firms. Barriers to entry include: (1) building networks of local providers and negotiating competitive reimbursement rates;[34] (2) establishing a credible reputation with area employers and consumers; (3) developing relationships with brokers, who serve as intermediaries for most purchasers; (4) achieving economies of scale in information technology, disease management, utilization review, and customer-service related functions. "Entry" into a given geographic market has tended to occur via acquisition. To wit, the most likely potential entrants in a market are incumbents in other product and/or geographic markets.[35] In light of the impediments to de

[33] 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: 16–35.

[34] This is a particularly salient barrier due to the "chicken and egg problem" of insurer-provider negotiations. Providers are generally willing to offer the most competitive rates to insurers with a large market share, however to gain market share an insurer needs to offer low premiums (and to do so sustainably, must have competitive provider rates).

[35] For example, recent entry in the private individual insurance market – sparked by the introduction of the Health Insurance Marketplaces and the individual mandate to carry insurance – has largely consisted of firms offering

novo entry, consolidation even in non-overlapping markets reduces the number of potential entrants who might attempt to overcome price-increasing (or quality-reducing) consolidation in markets where they do not currently operate.

3. How relevant is what we have learned in light of changes arising from the Affordable Care Act?

3.1. Applicability of merger retrospectives

A reasonable question to ask is whether the previously described retrospective analyses (of the Aetna-Prudential and United-Sierra mergers) are informative in light of the significant recent changes in the healthcare sector. The early evidence suggests that competition has its salutary effects on health insurance market even in the post-ACA world. One study (which I coauthored) finds that premiums on the individual exchanges in 2014 were more than 5 percent higher as a result of the decision by a large national insurer not to participate in federally-facilitated exchanges in that year.[36] Another study estimates that having an additional insurer in a given ratings area results in premium savings of nearly $500 per individual.[37]

3.2 The Medical Loss Ratio (MLR) regulations do not protect consumers from adverse consequences which may arise as a result of consolidation.

The ACA enacted sweeping regulatory changes on the commercial insurance industry, including minimum product standards, a requirement that insurers take all comers ("guaranteed issue"), a ban on medical underwriting, and limits on age-based pricing. However, the provision that is most relevant to the subject of insurer consolidation and its consequences concerns Medical Loss Ratios (MLRs). As of 2011, insurers must devote at least 85 (80) percent of premium revenues – net of taxes and licensing fees – to medical claims and quality improvement for their large group (small group/individual) fully-insured lives. Insurers failing to satisfy these requirements in any given state and market segment must refund the amount of the shortfall to their enrollees in the relevant segment.

Medicaid plans in those states. There are a number of new not-for-profit co-operatives as well, however entry of these organizations was subsidized by the federal government and many are not believed to be financially viable.

[36] Leemore Dafny, Jonathan Gruber, and Christopher Ody, "More Insurers, Lower Premiums: Evidence from Initial Pricing on the Health Exchanges," *American Journal of Health Economics,* Winter 2015: 53–81.

[37] 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," *American Economic Review*, 105.5 (2015): 120–25.

Some have argued[38] that these regulations mitigate concerns over potential anticompetitive consequences of consolidation in this sector. I do not find this argument convincing for at least five reasons.

First, more than half of privately-insured enrollees are in self-insured plans, and the minimum MLR regulations do not pertain to these plans.

Second, consumers are concerned with "value" for their health insurance dollar, and the minimum MLR restriction does not substitute for competition to provide value. Suppose there are two insurers competing in a given market segment, and both satisfy the MLR requirement for that segment. These insurers likely compete for enrollees on dimensions other than the share of spending devoted to medical claims and quality improvement activities, for example their product design, provider networks, customer service, and chronic disease management programs. Eliminating the competition (or potential competition) from this market via a merger relaxes or eliminates competition on these dimensions. Why expend effort in, say, developing shared savings programs to improve quality of care and reduce spending when you can still pocket the same margin per insured life?[39] In short, the MLR regulation attempts to cap industry profits, but it does not protect consumers from post-merger harm due to the loss of competition on a variety of relevant dimensions.

Third, for the MLR regulations to impact the usual analysis of consolidation effects, they must "bind": the statutory floors must be higher than we would otherwise see. For example, if insurers in a given market segment and state generally have MLRs above 90 percent, merging insurers benefiting from an increase in market power might still profitably raise profits and premiums by 5 percent. Although there are no published analyses of the MLR data that pinpoint where the regulations currently bind, a recent study by the non-profit Commonwealth Fund reports the following national MLRs for 2013: 85.9% (individual); 83.6% (small group); 88.6% (large group). These data suggest there may be substantial room for profitable merger-related price increases in the individual market in particular, notwithstanding the minimum MLR requirement.

In addition, because the MLR is calculated at the state and market level, it is conceivable that mergers can enable insurers to offset low MLRs in one geographic area or sub-segment with high MLRs in another. For example, consider an insurer offering plans in a (hypothetical) competitive, urban individual exchange ratings area, where MLRs tend to be on the high side (e.g., 90 percent). This insurer could be an attractive target for another insurer who offers plans

[38] *See, e.g.,* CNBC, "Aetna, Humana CEOs Talk Antitrust Concerns," Jul. 6, 2015, *available at* http://video.cnbc.com/gallery/?video=3000394309.

[39] Reductions in the value of insurance provided may reduce the total volume of insurance purchased, and hence provide some constraint on the reduction in value that a profit-maximizing monopolist insurer would impose. However, the demand for health insurance is relatively inelastic, and particularly so in light of the new insurance mandates.

in less-competitive rural markets. Post-merger, the insurer might be able to lower MLRs in these markets and use the "excess" spending in the target's market to offset these new profits.

Fourth, it may be possible to legally "game" the MLR regulation by effectively labeling profits as medical costs. For example, insurers often have ownership stakes in healthcare facilities and provider organizations. Such insurers could adjust internal transfer payments to these groups to ensure MLR minima are satisfied. Similarly, many insurers engage in quality improvement efforts. It would seem possible to create a separate quality improvement arm and to charge the insurance arm fees that offset profits in excess of the MLR minima. Although these possibilities are speculative, the main point is that regulation is an imperfect substitute for competition in terms of keeping premiums low for consumers.

Fifth, the minimum MLR regulation could be repealed. If we permit transactions that would otherwise be deemed anticompetitive under the belief that the MLR regulation acts as a check on post-merger margin increases, where are we left if a more consolidated insurance industry successfully argues for its repeal? As is well known to the Subcommittee, it is an order of magnitude more difficult to dissolve a consummated merger that proves anticompetitive than to prevent the transaction in the first instance.

3.3. Reforms to the healthcare delivery system may give rise to new efficiencies from consolidation, but at present these efficiencies are speculative.

The recent shift toward paying for value – rather than volume – of healthcare services will require significant changes in how insurers pay providers and how providers deliver and organize care. Some insurers have suggested that mergers will enhance their ability to develop and implement new value-based payment agreements.[40]

This claim embeds at least three possible sources of merger efficiencies (1) there are local economies of scale in implementation of value-based agreements; (2) there are non-local economies of scale in implementation of value-based agreements; (3) some insurers have a unique ability to implement such programs and others cannot replicate or access it without a merger.

Argument (1) implies that an insurer must have sufficient scale in a local market area to warrant the investment in changing practice patterns; if not, much of their investment in doing so will "spill over" and benefit rivals. Indeed, a recent study suggests the much-vaunted BCBS-MA Alternative Quality Contract for commercially-insured lives had a significant impact on

[40] For example, see Aetna's press release announcing the acquisition of Humana: "The combination will provide Aetna with an enhanced ability to work with providers and create value-based payment agreements that result in better care to consumers, and spread cutting-edge clinical practices and quality care." Aetna, "Aetna to Acquire Humana for $37 Billion, Combined Entity to Drive Consumer-Focused, High-Value Health Care," Jul. 3, 2015, *available at* https://news.aetna.com//news-releases/aetna-to-acquire-humana-for-37-billion-combined-entity-to-drive-consumer-focused-high-value-health-care/.

traditional fee-for-service Medicare enrollees.[41] BCBS-MA does not share in any savings generated for this population. At the same time, a provider can spread its fixed costs of collaborating with a given insurer across more lives the larger is that insurer. Although these are economically appealing arguments, at the moment they are theoretical. There is no evidence that larger insurers are more likely to implement innovative payment and care management programs. In addition, there is a countervailing force offsetting this heightened incentive to invest in payment and delivery system reform: more dominant insurers in a given insurance market are less concerned with ceding market share.

Argument (2) implies that scale across markets may be helpful in implementing value-based agreements. This might be true, for example, because of the ability to work with national employers to develop such programs. However, there is an opposing force that may also operate. Implementing new payment or care management models across disparate markets can introduce complexity and costs into national systems that are poorly designed for exceptions. For example, in early pilots of bundled payment programs, claims have been pulled for individual patients one-by-one out of claims payment processes. These costs are prohibitive and might lead to less, not more, innovation by payers with a cross-market presence. This reality may explain why concerted delivery system reform efforts have tended to emerge from other sources, such as provider systems (sometimes vertically integrated with insurers) and non-national payers like Massachusetts Blue Cross and Blue Shield.

Argument 3 is a standard claim of merger proponents and subject to all the usual forms of skepticism. Efficiencies must be merger-specific and verifiable if they are to be credited against potential harm arising from diminished competition, and there is still the question of whether benefits will be passed through to consumers in light of that diminished competition. Moreover, any short term gain from avoiding development costs for value-based programs may be offset by a reduction in long-term benefits arising from competition among insurers to develop better versions of these programs.

4. Next steps: How to assess proposed and potential consolidation going forward?

The Horizontal Merger Guidelines issued jointly by the FTC and DOJ explain how the DOJ will evaluate whether a proposed merger violates Section 7 of the Clayton Act. Some likely analyses include: (1) seeking detailed information on how costs will be trimmed *as a result* of any given transaction, and confirming they cannot be achieved in their absence or through means that are less likely to diminish competition; (2) soliciting input from state regulators and other informed stakeholders to gain an understanding of what mergers have proven beneficial in the past and the

[41] J. Michael McWilliams, Bruce E. Landon, and Michael E. Chernew, "Changes in Health Care Spending and Quality for Medicare Beneficiaries Associated with a Commercial ACO Contract," *JAMA*, 310.8 (2013): 829–836.

characteristics of these mergers; (3) seeking data on MLRs at a granular level, so as to assess the relationship between prior or proposed mergers and MLRs; (4) seeking information from CMS on how Medicare Advantage (MA) is impacted by market structure (both in and outside of MA); (5) evaluating the impact of mergers on prospective entry, and the role of prospective entrants in disciplining premium growth historically; (6) considering the implications of cross-market overlap on insurance competition. This is but a short list of potential analyses.

As the Subcommittee knows, ascertaining whether a transaction violates competition law is a different matter from ascertaining whether it is in the public interest. For example, a merger that is likely to lead to price increases without offsetting benefits may not violate Section 7 if it cannot be shown that the merger lessens competition in a relevant market. Different stakeholders might also place different weights on the potential losses and gains for various affected parties. Given the significance of the insurance sector to our wallets and to the functioning of our healthcare system, the public deserves better data with which to evaluate these transactions as well as the industry more generally. As a start, I would explore avenues for requiring detailed reporting on insurance enrollment, plan design, premiums, and medical loss ratios at a fine unit of geography (e.g., zip code) and for every possible customer segment. This reporting must include self-insured plans (and specifically, the insurance administration charges associated with such plans), as more than half of the privately-insured are enrolled in these types of plans. With these data in hand, policymakers and regulators will be able to monitor market developments and to intervene, if necessary, based on better and more timely information. And researchers such as myself will, in the future, be able to provide much stronger guidance regarding the likely effects of consolidation.

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Testimony

of the

American Hospital Association

before the

Subcommittee on Antitrust, Competition Policy and Consumer Rights

of the

Committee on the Judiciary

of the

U.S. Senate

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

September 22, 2015

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

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

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

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

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

SERIOUS CONCERNS ABOUT HEALTH INSURANCE CONSOLIDATION

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

Concentration Matters. A recent study[3] in *Technology Science* highlighted why this increasing concentration should be of particular concern. It found that the largest issuer in each state not only raised premiums by higher amounts, but also raised premiums on more of their plans than other issuers in the same state.

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

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

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

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

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

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

Claims of offsetting efficiencies cannot ameliorate the competitive harm from this deal. Insurers have a dismal track record of passing any savings from an acquisition on to consumers, and there is no reason to believe that this transaction would be any different.[7] In addition, neither of the legislated controls on excessive premium hikes – medical loss ratio (MLR) or rate review – are sufficient to prevent Anthem from raising rates to consumers above competitive levels.

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

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

Another concern is that Anthem's affiliation with the Blue Cross and Blue Shield (Blue) system raises some particular competitive concerns. An August 2015 letter[9] from Joe R. Whatley, Jr., to the Department described the Blue Cross Blue Shield Association's license agreement that prevents the individual Blue plans from directly competing against one another, and also prevents their non-Blue subsidiaries from competing even slightly vigorously against other Blue companies. The letter stated:

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

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

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

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

At a time of rising health insurance premiums, the Department and state Attorneys General should examine closely how this acquisition could increase Blue plan dominance nationwide. Blue Cross dominance has been an issue the Department has been concerned with in previous health insurance consolidations. In a speech by former Assistant Attorney General Christine Varney[10], she noted that local health plan dominance (i.e., Blue plan dominance) creates barriers to entry. And, the department has challenged two Blue plan mergers that would have increased that dominance. Given the size and scope of this deal and the dominance of the Blue plans nationwide, the Department should thoroughly investigate how the addition of Cigna to the Blues' arrangement could further entrench that widespread dominance and decrease competition, reduce the number of participating providers and lead to higher consumer premiums.

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

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

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

This is particularly concerning as there is almost a complete lack of competition in MA markets, according to an August 2015 report by the Commonwealth Fund[18], which found that 97 percent of MA markets in U.S. counties are "highly concentrated." This confirms the findings of a recent report by the Kaiser Family Foundation[19] that also described MA markets as highly concentrated. That report also noted that, while the MA program has continued to grow in virtually all states, MA plans now provide less financial protection for enrollees and average out-of-pocket expenses have continued to climb; this is not an unexpected development in such highly-concentrated markets.

A somewhat perplexing new report from Avalere[20] suggests that both the Commonwealth Fund and Kaiser are wrong. The report claims there is new market entry and growth, as well as diversification in MA markets. These new entrants mainly comprise a Blue plan and 15 provider-owned plans. While provider-owned plans offer seniors an excellent choice in the geographic areas they cover, they cannot begin to replace the loss of competition in more than 1,000 markets in 38 states for the 2.7 million seniors that are at risk because of this transaction. Furthermore, some skepticism should be applied to any characterization of a Blue plan as a new entrant into a health insurance market.

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

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

WHY HOSPITAL DEALS ARE DIFFERENT

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

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

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

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

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

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

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

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

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

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

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

MOVING TO A VALUE-BASED REIMBURSEMENT SYSTEM

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

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

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

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

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

INCREASED CAPITAL REQUIREMENTS

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

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

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

NEW COMPETITION FOR HOSPITAL SERVICES

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

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

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

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

CONCLUSION

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

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

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[1] *www.aha.org/letters*
[2] Competition in Health Insurance A comprehensive study of U.S. markets, American Medical Association, 2015 Update, https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product_id=prod2680007&navAction=push#usage-tab.
[3] Wang E, Gee G. Larger Issuers, Larger Premium Increases: Health insurance issuer competition post-ACA. *Technology Science*. 2015081104. August 11, 2015. http://techscience.org/a/2015081104.
[4] AHA letter to the Honorable William Baer, August 5, 2015.
[5] This $1.5 billion Startup is Making Health Insurance Suck Less, Wired, March, 20, 2015 http://www.wired.com/2015/04/oscar-funding/.
[6] Tough Going for Co-Ops, New York Times, September 15, 2015.
[7] Testimony of Professor Thomas L. Greaney, Before the House of Representatives Subcommittee on Regulatory Reform, Commercial and Antitrust Law, September 10, 2015.
[8] Insurers Win Big Health-Rate Increases, Wall Street Journal, August 27, 2015. http://www.wsj.com/articles/insurers-win-big-health-rate-increases-1440628848.
[9] Joe R. Whatley, Jr., letter to the Honorable William Baer, August 13, 2015.
[10] Remarks of Christine Varney, then Assistant Attorney General of the DOJ's Antitrust Division, at a joint American Bar Association/American Health Lawyers Association Antitrust in Healthcare Conference, May 24, 2010, available at http://www.justice.gov/atr/speech/antitrust-andhealthcare
[11] Reporting on divestitures ordered in the car rental and grocery store industries. Divestitures required were 58 on-airport locations and a line of business for the Hertz deal and 168 supermarkets in 130 locations for Albertsons. http://pipeline.thedeal.com/tdd/ViewArticle.dl?s=dd&id=13291361&cmpid=em:DA091715#ixzz3m1SYWNdc

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

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By Email and Courier

September 1, 2015

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

The Honorable Sylvia Burwell
Secretary
Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Assistant Attorney General Baer and Secretary Burwell:

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

/s/

Melinda Reid Hatton
Senior Vice President & General Counsel

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

Attachment

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

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

1. The Parties

A. Aetna

Aetna is one of the nation's largest health insurance companies, with $58 billion in revenues in 2014.[9] The company is financially strong, and boasted of "strong growth" in its "core businesses" in 2014, when it set records in both operating revenues and operating earnings.[10]

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[4] Aetna news release, *available at* https://news.aetna.com//aetna-to-acquire-humana/.
[5] 15 U.S.C. § 18.
[6] Gretchen Jacobson, Anthony Damico, and Marsha Gold, Kaiser Family Foundation Issue Brief, *Medicare Advantage 2015 Spotlight: Enrollment Market Update*, (June 30, 2015), Figure 1, *available at* http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/ (hereafter "KFF June 2015 Issue Brief").
[7] *Id.* at 13. In fact, in a report released just days ago, The Commonwealth Fund found that 2,852 of the 2,933 counties studied (97 percent) have "highly concentrated" MA markets, using the definition for that term set forth in the Department of Justice's merger guidelines. Brian Biles, Giselle Casillas, and Stuart Guterman, *Competition Among Medicare's Private Health Plans: Does It Really Exist?*, The Commonwealth Fund (August 25, 2014), *available at* www.commonwealthfund.org/publications/issue-briefs/2015/aug/competition-medicare-private-plans-does-it-exist.
[8] KFF June 2015 Issue Brief at Fig. 14; *see also* Anna Wilde Mathews, Liz Hoffman, Dana Mattioli, *With Merger Deal, Aetna, Humana Get Ahead of the Pack*, Wall Street Journal (July 6, 2015) (the combined companies "would have about a million more members in Medicare Advantage … than their next-closest competitor, UnitedHealth"), *available at* www.wsj.com/articles/with-merger-deal-aetna-humana-get-ahead-of-the-pack-1436143581.
[9] Aetna Annual Report (2014) at 2, *available at* http://phx.corporate-ir.net/External.File?item=UGFyZW50SUQ9NTc0OTUyfENoaWxkSUQ9Mjc4NDQyfFR5cGU9MQ==&t=1. $55 billion are derived from Aetna's health care businesses.
[10] *Id.*

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

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

B. Humana

Humana also is one of the largest health insurers in the U.S., with more than $48 billion in total revenues in 2014.[15] It has almost 14 million medical members.[16]

The company has long been a leader in Medicare products. The company offers at least one Medicare product in every state.[17] Humana today is the second largest Medicare Advantage insurer in the U.S., just behind UnitedHealthcare.[18] Fully 54 percent of Humana's revenues derive from Medicare Advantage products.[19] Total Medicare Advantage membership increased 18 percent between 2013 and 2014.[20] Humana claims that its strength in Medicare Advantage provides it "with greater ability to expand our network of PPO and HMO providers" and so it is well positioned to maintain and expand its strength in Medicare Advantage markets.[21]

2. Application of the Antitrust Laws to this Transaction

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

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[11] Aetna Annual Report (2014) at 10.
[12] *Id.*
[13] Mark T. Bertolini, Chairman and CEO, Letter to shareholders (April 2015), *available at* http://phx.corporate-ir.net/External.File?item=UGFyZW50SUQ9NTc0OTUyfENoaWxkSUQ9Mjc4NDQyfFR5cGU9MQ==&t=1.
[14] *Id.*
[15] Humana 10-K for YE 2014 (attached to 2014 Annual Report), at 81, *available at* http://phx.corporate-ir.net/External.File?item=UGFyZW50SUQ9NTcyNjgzfENoaWxkSUQ9Mjc0NTQ3fFR5cGU9MQ==&t=1.
[16] *Id.* at 12; *see also id.* at 38.
[17] *Id.* at 5.
[18] KFF June 2015 Issue Brief at Fig. 14.
[19] Humana 10-K for YE 2014 (attached to 2014 Annual Report), *supra*, at 5.
[20] 2014 Annual Report, *supra*, at 3.
[21] Humana 10-K for YE 2014 (attached to 2014 Annual Report), *supra*, at 5.
[22] Letter from Melinda Reid Hatton to William Baer, at 7 (August 5, 2015), *available at* http://www.aha.org/advocacy-issues/letter/2015/150805-let-acquisitions.pdf.

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

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

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

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[23] Sharis A. Pozen, Acting Assistant Att'y Gen., Dep't of Justice Antitrust Div., *Competition and Health Care: A Prescription for High-Quality, Affordable Care* (Mar. 19, 2012), at 4, 6, *available at* www.justice.gov/atr/speech/competition-and-health-care-prescription-high-quality-affordable-care. Less than two year earlier, Christine Varney, then Assistant Attorney General of the DOJ's Antitrust Division, made a similar point in remarks given to a joint American Bar Association/American Health Lawyers Association Antitrust in Healthcare Conference, (May 24, 2010), *available at* http://www.justice.gov/atr/speech/antitrust-and-healthcare.

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

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

[26] *Id.* at ¶ 3.

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

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

A. Relevant Product Market

1. The Medicare Advantage Program

a. Medicare Advantage Before The Passage Of The ACA

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

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[28] Complaint, *United States v. Humana Inc. and Arcadian Management Services, Inc.*, No. 12-cv-464 (D.D.C., March 27, 2012), *available at* www.justice.gov/atr/case/us-v-humana-inc-and-arcadian-management-services-inc.
[29] *Id.* at ¶ 4.
[30] *Id.*
[31] Final Judgment, *United States v. Humana Inc. and Arcadian Management Services, Inc.*, No. 12-cv-464 (D.D.C., Sept. 21, 2012), *available at* www.justice.gov/atr/case/us-v-humana-inc-and-arcadian-management-services-inc.; *see also* Competitive Impact Statement (March 27, 2012) (available at same website).
[32] Competitive Impact Statement, *United States v. Humana*, *supra*, at 1.
[33] *United States v. UnitedHealth Group Inc. and Sierra Health Services, Inc.*, No. 08-cv-322, *available at* www.justice.gov/atr/case/us-v-unitedhealth-group-inc-and-sierra-health-services-inc.; *United States v. Humana Inc. and Arcadian Management Services, Inc.*, No. 12-cv-464, *available at* www.justice.gov/atr/case/us-v-humana-inc-and-arcadian-management-services-inc.

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

- The deductible for hospitalization under Medicare Part A is $1,260 in 2015. If a hospital stay lasts longer than 60 days, prescribed coinsurance amounts must be paid by the beneficiary.[36]

- The deductible for Medicare Part B this year is $147.[37]

    - Once beneficiaries meet the deductible, they typically must pay 20 percent of the Medicare allowed amounts.

- There is ***no*** annual limit on out-of-pocket costs incurred under either Part A or Part B. "If beneficiaries want to limit potentially catastrophic out-of-pocket costs, they need to purchase a separate Medicare Supplement plan."[38]

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

- ***Additional benefits.*** Medicare Advantage plans may (and usually do) provide benefits not provided by Medicare. These additional services often include dental and vision benefits, and may include hearing and health and wellness programs.[39]

- ***Prescription drug coverage.*** The overwhelming majority of Medicare Advantage enrollees (88 percent) participate in a plan (an MA-PD) that includes a prescription drug benefit.[40]

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

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

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

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

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

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

[40] KFF June 2015 Issue Brief at 7.

- The standard Part D benefit design has a $320 deductible and requires 25 percent coinsurance up to $2,960 in drug costs.[41] At that expenditure level, a "donut hole" opens: beneficiaries are responsible for 45 percent of the cost of the drug (in 2015) until their out-of-pocket hits $4,700, after which they pay 5 percent of their drug costs.[42]

- Enrollees in MA-PDs generally have better coverage than do those who must buy a Part D plan directly: fully 58 percent of MA-PD enrollees participate in plans that have *no* Part D deductible.[43] Such no-deductible drug plans are more common in Medicare Advantage than in Part D plans available to traditional Medicare enrollees.[44] And, almost half (45 percent) of MA-PD enrollees are in plans that close some of the "donut hole" in Part D's drug coverage.[45]

- ***Premium cost.*** The average enrollee in a MA-PD plan in 2015 pays a monthly plan premium of about $38.[46] Medicare Advantage plans may use savings to reduce—sometimes to zero—the premiums they charge for coverage. In 2015, 78 percent of all MA-PD enrollees had a choice of at least one plan that charged nothing for Medicare Advantage coverage, leaving enrollees responsible only for their Part B premium.[47] Almost one-half of all MA-PD enrollees participate in these "zero-premium" plans.[48] Some plans go even further, and use their savings to reduce the Part B premium.[49]

- ***Out-of-pocket limits.*** Medicare Advantage plans must limit out-of-pocket expenditures for Part A and Part B services.[50] The out-of-pocket limit in 2015 can be no greater than $6,700 per Medicare Advantage enrollee annually. In fact, the average out-of-pocket limit in 2015 is less: $5,041 per enrollee.[51]

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

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[41] KFF June 2015 Issue Brief at 11.
[42] *Id.*
[43] *Id.*
[44] Gretchen Jacobson, Anthony Damico, Tricia Neuman, and Marsha Gold, Kaiser Family Foundation Issue Brief, *Medicare Advantage 2015 Data Spotlight: Overview of Plan Changes*, (Dec. 10, 2014), at 11, *available at* http://files.kff.org/attachment/data-spotlight-medicare-advantage-2015-data-spotlight-overview-of-plan-changes
[45] KFF June 2015 Issue Brief at 11.
[46] KFF June 2015 Issue Brief at 8.
[47] *Id.* at 8.
[48] *Id.*
[49] Medicare Payment Advisory Commission ("MedPAC"), *Report to the Congress: Medicare Payment Policy*, (March 2015), Ch. 13, *available at* www.medpac.gov/documents/reports/chapter-13-the-medicare-advantage-program-status-report-(march-2015-report).pdf?sfvrsn=0 .
[50] *Id.*
[51] KFF June 2015 Issue Brief at 10.
[52] According to MedPAC, as of February 2015, about 3 million enrollees were in employer group plans, or about 19 percent of all Medicare Advantage enrollees. About 2 million were in special needs plans. MedPAC, *A Data Book,*

organization (HMO).[53] Preferred provider organizations (PPOs) provide coverage to 31 percent of the enrollees. Just 5 percent of all Medicare Advantage enrollees obtain services through private fee-for-service plans,[54] and that proportion has "fallen precipitously" since 2008.[55] Consistent with the usual way in which HMOs and PPOs operate, enrollees in these plans usually obtain care from a more limited network than offered by traditional Medicare, and these plans (and in particular, the HMOs) typically manage the care provided.[56]

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

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

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

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

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

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

[55] *Id.*

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

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

[58] *Id.*

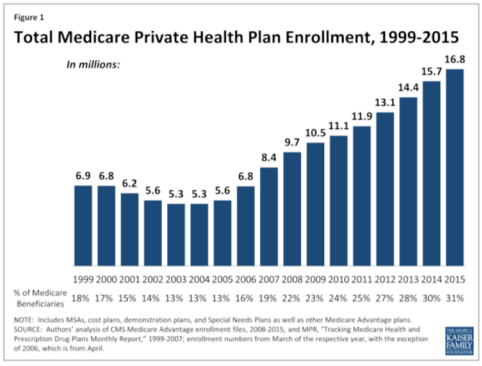
[59] *Id.*

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

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

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

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



This enrollment increase has occurred at the same time that CMS has ratcheted down the payments to Medicare Advantage plans from the average of 114 percent of the amount expended per fee-for-service enrollee in 2009,[65] to just 102 percent in 2015.[66] And, while total Medicare Advantage enrollment has been growing quickly, and is projected to continue to grow to 25 million over the next 10 years,[67] the number of Medicare Advantage plans is *declining*.[68]

2. Medicare Advantage Constitutes A Separate Relevant Product Market

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

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

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

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

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

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

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

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

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

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

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

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

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[69] Competitive Impact Statement, *United States v. UnitedHealth*, *supra*, at 7; *see also* Competitive Impact Statement, *United States v. Humana*, *supra*, at 4.
[70] Competitive Impact Statement, *United States v. Humana*, *supra*, at 5.
[71] *Id.*
[72] *See* ABA Section of Antitrust Law, *Antitrust Law Developments* (7th ed. 2012) at 595-99 (broad recognition of cluster markets in industries including hospital services, financial services, office supply superstores, and others).
[73] *See generally* Gretchen Jacobson, Christina Swoope, Michael Perry, Mary Slosar, *How are seniors choosing and changing health insurance plans?*, Henry J. Kaiser Family Foundation (May 2014) at 12 ("Seniors say they have tried to compare the costs, coverage, and provider networks of plans, but find it frustrating and confusing"), *available at* https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8589-how-are-seniors-choosing-and-changing-health-insurance-plans.pdf.

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

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

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

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

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

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[74] Competitive Impact Statement, *United States v. UnitedHealth*, *supra*, at 4-5.
[75] Competitive Impact Statement, *United States v. Humana*, *supra*, at 6 ("a small but significant increase in Medicare Advantage plan premiums or reduction in benefits is unlikely to cause a sufficient number of seniors in the relevant geographic markets to switch to traditional Medicare such that the price increase or reduction in benefits would be unprofitable").
[76] *See generally* KFF June 2015 Issue Brief at 8-12.
[77] CBO, *Comparison of Projected Enrollment in Medicare Advantage Plans and Subsidies*; *see generally* KFF June 2015 Issue Brief at 1; Gretchen A. Jacobson, Patricia Neuman, Anthony Damico, *At Least Half Of New Medicare Advantage Enrollees Had Switched From Traditional Medicare During 2006–11*, 34 Health Affairs 48, 49 (Jan. 2015), *available at* http://content.healthaffairs.org/content/34/1/48.full.pdf.
[78] *Id.*

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

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

B. Relevant Geographic Market

Consistent with the Department's practice in the UnitedHealth/Sierra[84] and Humana/Arcadian[85] mergers, the relevant geographic markets in which to evaluate the proposed Aetna/Humana merger are at the county (or parish) level. CMS approves Medicare Advantage plans on a county-by-county basis,[86] and the vast majority of seniors may only enroll in a Medicare Advantage plan in the county in which they live.[87]

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

[80] Gretchen A. Jacobson, Patricia Neuman, Anthony Damico, *At Least Half Of New Medicare Advantage Enrollees Had Switched From Traditional Medicare During 2006–11*, 34 Health Affairs 48, 51 (Jan. 2015), *available at* http://content.healthaffairs.org/content/34/1/48.full.pdf.

[81] *Id*. at 53.

[82] *Id*.

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

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

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

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

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

C. Competitive Effects

Under the Merger Guidelines, a "highly concentrated market" is one where the Herfindahl-Hirschman Index (HHI) is 2500 or more.[88] "Mergers resulting in highly concentrated markets that involve an increase in the HHI of between 100 points and 200 points potentially raise significant competitive concerns and often warrant scrutiny. Mergers resulting in highly concentrated markets that involve an increase in the HHI of more than 200 points will be presumed to be likely to enhance market power."[89] Consistent with this approach, our analysis identifies counties where (1) both Aetna and Humana have Medicare Advantage membership, (2) the post-merger HHI is at least 2,500, and (3) the merger produces an increase of at least 100 points.

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

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

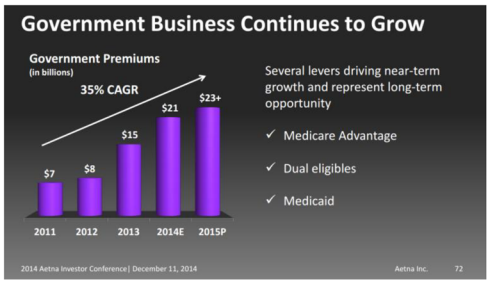
	HHI Delta Screen	
	>200	**>100**
Number of Counties	924	1,083
Aetna Membership	784,167	842,864
Humana Membership	1,612,941	1,878,082
Total Aetna/Humana membership	2,397,108	2,720,946
Membership to Divest (smaller plan)	581,050	610,278

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

[88] Horizontal Merger Guidelines, U.S. Department of Justice and Federal Trade Commission (August 19, 2010) at § 5.3, *available at* www.justice.gov/atr/horizontal-merger-guidelines-08192010.
[89] *Id.*
[90] We exclude Special Needs Plans, as the Department did in both UnitedHealth/Sierra and Humana/Arcadian.
[91] *Available at* www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County-Items/Monthly-Enrollment-by-CPSC-2015-06.html.

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

[99] *Id.* at n.84.

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

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

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

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

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

2. Entry

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

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

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

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

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

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

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

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

E. Remedies

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

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

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

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[107] Competitive Impact Statement, *United States v. Humana*, at 8.
[108] Competitive Impact Statement, *United* States v. *UnitedHealth*, at 8-9.
[109] The federal antitrust enforcement agencies have opposed mergers where the divestitures that might otherwise have been required to preserve competition were so numerous as to cast serious doubt on the use of divestitures as a remedy. *See, e.g.*, *FTC v. Sysco Corp.*, No. 15-cv-256-APM, 2015 U.S. Dist. LEXIS 83482, at *76–78 (D.D.C. June 23, 2015); *United States v. AT&T Inc. and T-Mobile*, Case: 1:11-cv-01560 (D.D.C. Aug. 31, 2011), *available at* www.justice.gov/atr/case/us-and-plaintiff-states-v-att-inc-et-al; Press Release, Department of Justice, Blue Cross Blue Shield of Michigan and Physicians Health Plan of MidMichigan Abandon Merger Plans: Decision to Abandon Deal Follows Justice Department's Decision to Challenge the Acquisition (Mar. 8, 2010). www.justice.gov/opa/pr/blue-cross-blue-shield-michigan-and-physicians-healthplan-mid-michigan-abandon-merger-plans.

3. **Conclusion**

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

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

[110] Competitive Impact Statement, *United States v. Humana*, at 8.
[111] *Id.*
[112] Complaint, *United States v. Humana* at ¶ 4.

American Hospital Association

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By Email and Courier

August 5, 2015

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

Dear Assistant Attorney General Baer:

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

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

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

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

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

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

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

Sincerely,

/s/

Melinda Reid Hatton
Senior Vice President & General Counsel

Attachment

Detailed Analysis of the American Hospital Association

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

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

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

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

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1 15 U.S.C. § 18.

2 *Merger Guidelines* § 5.3.

3 *Id.*

4 Sharis A. Pozen, Acting Assistant Att'y Gen., Dep't of Justice Antitrust Div., *Competition and Health Care: A Prescription for High-Quality, Affordable Care* 7 (Mar. 19, 2012) [hereinafter Pozen, *Competition and Health Care*], *available at* http://www.justice.gov/atr/speech/competition-and-health-care-prescription-high-quality-affordable-care.

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

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

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

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

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

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

7 *See id.*

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

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

1. The Parties

A. Anthem

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

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

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

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

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

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

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

B. Cigna

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

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

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

2. The Antitrust Laws Applied to Health Insurance Mergers

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

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

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

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

14 *Id.*

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

16 *Id.* at 4.

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

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

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

A. Relevant Product Market

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

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

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

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

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

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

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

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

B. Relevant Geographic Market

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

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

C. Competitive Effects

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

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

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

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

23 *See id.* at ¶¶ 27–29.

Guidelines further provide that "[m]ergers resulting in highly concentrated markets that involve an increase in the HHI of more than 200 points will be presumed to be likely to enhance market power."[24] Mergers resulting in highly concentrated markets that involve an increase in the HHI of between 100 points and 200 points potentially raise significant competitive concerns and often warrant scrutiny.[25]

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

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

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

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

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24 *Merger Guidelines* § 5.3.

25 *See id.*

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

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

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

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

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

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

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

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

D. Entry

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

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

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

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

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

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

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

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

32 *See* Pozen, *Competition and Health Care* at 7 ("brokers typically are reluctant to sell new health insurance plans, even if those plans have substantially reduced premiums, unless the plan has strong brand recognition or a good reputation in the geographic area where the broker operates.")

E. Remedies

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

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

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

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

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

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

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

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

F. Medical Loss Ratio

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

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

3. Conclusion

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

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35 *Id.* at 17–18.

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

ConsumersUnion
POLICY & ACTION FROM CONSUMER REPORTS

STATEMENT OF GEORGE SLOVER
SENIOR POLICY COUNSEL
CONSUMERS UNION

BEFORE THE

SUBCOMMITTEE ON ANTITRUST, COMPETITION
POLICY AND CONSUMER RIGHTS
SENATE COMMITTEE ON THE JUDICIARY

ON

EXAMINING CONSOLIDATION
IN THE HEALTH INSURANCE INDUSTRY
AND ITS IMPACT ON CONSUMERS

September 22, 2015

Chairman Lee, Ranking Member Klobuchar, Subcommittee Members, thank you for the opportunity to be here today, and to discuss our concerns with the impact on consumers from undue consolidation in the health insurance industry.

Consumers Union is the public policy and advocacy arm of Consumer Reports. Our mission is to work for a fair, just, and safe marketplace for all consumers, and to empower consumers to protect themselves. And one key to empowering consumers to protect themselves is working to ensure meaningful consumer choice, through effective competition.

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

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

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

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

policies sold on the new exchanges. In these and numerous other ways, regulation can promote improved health care delivery and improved cost control.

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

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

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

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

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

Health insurers play a key role in helping make the health care system work for consumers. We see that every time we look at a medical bill and read the markdown for the disallowed portion – the difference between what the provider would like to charge us, and what it is willing to accept to be part of our health care plan's network.

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

As the Justice Department has explained, where there is effective competition, insurers compete against each other by offering plans with lower premiums, reducing copayments, lowering or eliminating deductibles, lowering annual out-of-pocket maximum costs, managing care, improving drug coverage, offering desirable benefits, and making their provider networks more attractive to potential members.[1]

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

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

It is with all this in mind that we look at concentration in health insurance, and the proposed Aetna/Humana and Anthem/Cigna mergers. The Justice Department's investigations are just getting underway. But there are strong indicators, to us, that these mergers could create too much concentration, in too many markets, and cause too much harm to consumer choice.

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

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

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

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

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

Taking the longer view is also important because, if the Justice Department were to stand by and allow concentration to increase right up to the very brink of obvious and immediate harm, there's no margin for error, or for all-too-foreseeable developments beyond the control of the antitrust laws or anyone else. What if one of the current key players later decides to downsize or close shop? The antitrust laws don't force someone to work, and they don't force a company to stay in business.

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

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

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

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

One justification we've heard for approving these mergers is that giving these insurance companies more market power will offset the market power of hospitals

and doctor groups. We are certainly aware of, and concerned about, increased concentration that has been taking place in provider markets – and how it can lead to less choice for consumers, and higher premiums and costs, and less value.

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

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

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

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

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

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

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

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

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

Thank you again for the opportunity to testify on this important issue for consumers.

Prepared Statement by Senator Chuck Grassley of Iowa
Chairman, Senate Judiciary Committee
Subcommittee Hearing on Examining Consolidation in the Health Insurance Industry and its Impact on Consumers
Tuesday, September 22, 2015

Mr. Chairman, thank you for holding this important hearing to examine the proposed mergers in the health insurance industry.

Currently, the health insurance industry is comprised of five major insurance companies: Aetna, Humana, Anthem, Cigna, and UnitedHealth Group. If these two transactions are approved by the Department of Justice, the number of major health insurance carriers would be reduced from five, to only three. But that of course is just the beginning of the discussion.

The Department will be examining these transactions closely, as they should. They'll be looking at the relevant product and geographic markets, as well as issues like the "ease of entry" for new market participants.

I believe in vigorous enforcement of our antitrust laws. Free and fair competition is good for markets. And it's good for consumers. So, I'm eager to hear from our witnesses today.

As I do, I'll be listening carefully to learn how these transactions will benefit ordinary, hard-working Americans.

Thank you again, Mr. Chairman. And thank you to all of our witnesses for being here today.

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Statement of Senator Patrick Leahy (D-Vt.),
Ranking Member, Senate Judiciary Committee,
Subcommittee Hearing on "Examining Consolidation in the Health Insurance Industry and its Impact on Consumers"
September 22, 2015

Few industries play as crucial a role in the quality of life of consumers as the health insurance industry. Access to affordable and quality healthcare coverage is a necessity for all Americans, and ensuring a competitive marketplace is important in making that kind of access a reality. The Judiciary Committee's Subcommittee on Antitrust is doing important work today in reviewing two significant mergers in this space and evaluating the potential impact on consumers.

The competitive state of the health insurance industry impacts consumers in multiple ways. The marketplace for buying insurance policies is often what is most front-of-mind for consumers, but the relationship between healthcare providers and insurance companies has a significant impact on them as well. Consumers can find themselves caught in the middle between two powerful forces. In Vermont, consumers can only choose between two insurance companies and I want to learn more about how these proposed mergers will affect the health insurance market in my state. I hope that the witnesses today will address the effect these proposed transactions will have on this aspect of the market.

The antitrust laws exist to promote competition and protect consumers. Competition keeps prices lower and creates more options for those looking to buy. I have long been troubled that the health insurance industry has a special, statutory exemption from the antitrust laws. There is no justification for the health insurance industry to be exempt from laws that prohibit price-fixing and other anticompetitive practices. For years, I have worked on a bipartisan basis to end the insurance industry's antitrust exemption and I continue to believe that it should end. If the health insurance industry becomes more consolidated, I fear that the lack of antitrust protection for consumers will exacerbate any possible harms that the witnesses today may touch on.

I thank Senator Lee and Senator Klobuchar for their continued commitment to reviewing important transactions that affect the country. The Judiciary Committee plays a key role in highlighting any concerns that may arise from these kinds of mergers. Our efforts augment the detailed review that will be undertaken by the antitrust authorities. I look forward to reviewing the testimony of the witnesses today.

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Opening Statement

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

Senator Mike Lee

September 22, 2015

Welcome to this hearing of the Subcommittee on Antitrust, Competition Policy, and Consumer Rights. Before we start, I would like to thank Ranking Member Klobuchar and her staff for their assistance in preparing for today. I'd also like to thank the Chairman of the full committee, Senator Grassley, for his support for the hearing.

[Housekeeping matters]: A few housekeeping matters before we begin. After I and Senator Klobuchar give some opening remarks about this hearing, we will hear from our panel of witnesses (who I'll introduce later on), and then we will have five-minute question rounds. I should also note that we are expecting an important vote on the floor this morning and I and other members will likely need to step out briefly to participate. If necessary, we may briefly pause the hearing proceedings.

Introduction

We're here today to discuss the proposed mergers between four of the nation's five largest health insurance companies. In early July this year, Aetna announced it had reached a deal to purchase rival Humana for $37 billion. A few weeks later, Anthem announced its own deal to purchase Cigna for $54 billion. The Department of Justice is currently reviewing the proposed transactions, and should they proceed without any objection or substantial modification, the health insurance industry's so-called "Big Five" will be reduced to the "Big Three": UnitedHealthcare, Anthem, and Aetna.

As with any merger between two major competitors, each of these acquisitions raises the question of whether the merging businesses' product offerings overlap in any geographic market. The relevant

antitrust inquiry is whether the combination will lead to a market concentration that may substantially lessen competition.

These transactions and their concurrent review also raise questions about the broader issue of consolidation in the health insurance industry. It is my hope that our discussions today will assist the public and lawmakers in understanding what is causing the trend towards consolidation, as well as how it will affect consumers. As we have seen since the passage of the Affordable Care Act, sudden and drastic changes to the healthcare markets can lead to financial uncertainty and increased strain on consumers and their families.

While vibrant competition in every industry is important to our economy, consumers and policy makers pay special attention when healthcare is involved. Healthcare markets are distinguished from those for other goods and services by their complexity, financial incentives, and inelastic demand. Health-related goods and services reach consumers through a byzantine web of manufacturers, wholesalers, pharmacy benefit managers, insurance companies and other third-party payors, providers, pharmacies, state and federal government agencies, and sometimes employers. In many instances, those prescribing care, those receiving the care, and those paying for the care are all different entities. But despite these complexities, and despite the often high costs for healthcare, everyone will at some point require it. Of course, healthcare also touches on some of the most sensitive and life-changing decisions made by consumers, decisions that have a lasting impact on their *personal* as well as economic well-being.

The Proposed Transactions

That brings us to the present transactions. The first to be announced was that between Aetna and Humana, the third and fifth largest national health insurers, respectively. Aetna serves an estimated 46 million people globally, offering a variety of health insurance products, including dental, vision, Medicaid, Medicare Supplemental, Medicare Advantage, and commercial policies. Aetna's primary focus is in commercial health insurance, particularly national accounts and large multi-site self-insured employers. Humana has over

14 million members and product offerings focusing on Medicare, with at least one Medicare product in every state. Humana is the second largest Medicare Advantage provider behind UnitedHealthcare.

The second transaction, between Anthem and Cigna, proposes to combine the second and fourth largest national health insurers, respectively. Anthem is the largest member of the Blue Cross and Blue Shield Association, operating under that brand in 14 states. Anthem has over 38 million health insurance customers spread across its small group, Medicare, Medicaid, individual, and commercial products. Cigna has over 14 million covered lives and focuses on commercial health insurance offerings.

Competitive Concerns

Each of these deals is incredibly complex and raises its own set of unique concerns. Industry observers have noted that the primary area of overlap between Aetna and Humana is in their Medicare Advantage businesses. The American Hospital Association identified nearly a thousand counties in which the post-acquisition concentration level in the market for Medicare Advantage raises strong competitive concerns. Others, however, question both the accuracy of the data cited and its interpretation. While some are concerned the deal will lead to higher prices and fewer choices for consumers, the companies have identified $1.25 billion in potential efficiencies.

The Anthem-Cigna merger is viewed to involve overlap primarily in the commercial health insurance market. The American Hospital Association claims the deal may result in concerning concentration levels for commercial health insurance products in up to 807 metropolitan areas. The insurance companies again strongly dispute these numbers, arguing that they fail to separate out different insurance products that are in different product markets. Anthem and Cigna believe they are joining complementary businesses in a way that will allow them to lower costs and improve quality for consumers.

Anthem's acquisition of Cigna also raises questions regarding how Cigna will be integrated into the Blue Cross Blue Shield system.

Anthem's membership agreement in the Association places limits on how much of their business may be conducted outside the Blue Cross and Blue Shield brands. It is possible that Cigna's ability to compete post-acquisition may be constrained by Anthem's membership in the Blue Cross and Blue Shield Association. For their part, Anthem believes that the addition of Cigna's members will not cause them to run into any limits imposed by the Association's membership agreement.

In addition, there is the question of how these mergers may effect nascent forms of competition in the health insurance industry, specifically the trend towards value-based reimbursement and outcome-based treatment models. These alternative approaches to healthcare seek to improve care and lower costs by focusing on patient outcomes and overall health, particularly through preventative care, rather than simply paying for services on a fee-basis. As the marketplace evolves in response to consumer demand and government policies, it will be important to ensure that consumers are benefitting from vigorous competition and wide choice, rather than being locked into the offerings of a few dominant companies.

Finally, we can't ignore the far-reaching effect that the Affordable Care Act has had on the insurance marketplace. While I would like to emphasize that this is not a hearing on Obamacare, a discussion of its role in current industry consolidation is unavoidable given the way the Act has transformed the structure and provision of health insurance in America. It is important for us to ask how it may be affecting competition in these markets.

Conclusion

As we can see, the issues raised by these proposed transactions and the complexities of the healthcare space provide ample topics of discussion. While the final determination regarding the competitive impact of the deals will be made by the Department of Justice, I believe we can make valuable contributions to the conversation today by closely examining any concerns they raise and by looking at what other forces or market realities may be driving consolidation in the health insurance industry.

Particularly at a time when the debate over national healthcare policy continues with fervor, and the healthcare marketplace is rapidly evolving to meet the demands of the 21st century, it is essential that lawmakers and regulators in Washington pay close attention to the impact of our actions on competition and the free market. I hope that we can make strides to that end today and I look forward to hearing and engaging with the testimony of our highly qualified panel of witnesses.

Hearing before the Senate Committee on the Judiciary
"Examining Consolidation in the Health Insurance Industry and its Impact on Consumers"
Question for the Record Submitted by Senator Al Franken

Question for Dr. Dafny

In your testimony, you call for greater transparency and more research regarding the effects of consolidation in the health insurance industry. Can you describe what you mean? What kind of data should we be collecting that will shed more light on this critical issue?

Aetna Responses
To
Questions for the Record

U.S. Senate Committee on the Judiciary

Subcommittee on Antitrust, Competition Policy and Consumer Rights Hearing

"Consolidation in the Health Insurance Industry and its Impact on Consumers"

September 22, 2015

Senators with Submitted Questions:

- Dianne Feinstein (D-CA)
- Thom Tillis (R-NC)
- Orrin Hatch (R-UT)
- David Vitter (R-LA)
- Patrick Leahy (D-VT)
- Mike Lee (R-UT)

Questions for the Record from Senator Dianne Feinstein

1. **Medical loss ratio refers to the percentage of premium dollars that go toward medical care for patients versus administrative costs. Companies that are merging often tout increased administrative efficiencies.**

   a. **Do you expect that increased efficiencies would translate into increased medical loss ratio percentages for Aetna in comparison to the last two years?**

   Aetna's acquisition of Humana is about Medicare. The primary goal is to enable us to offer more consumers a broader choice of products and access to higher quality, more affordable care.

   After the transaction, we expect to achieve over $1 billion in cost savings each year. We expect that a significant portion of these savings will flow back to consumers in the form of more cost-effective high quality product offerings in more areas across the country. Our goal is to remove waste and duplicative administrative costs and use some of the savings to develop products to keep people healthier.

   The Medical Loss Ratio (MLR) is clearly a part of the regulatory landscape in Medicare Advantage (as well as for many of our other segments). Most Aetna plans today already outperform the federal MLR requirements in terms of the balance of patient care to administrative expenses, and we expect this will continue following the transaction.

   It is also worth noting that Medicare Advantage plans, governed by the federal bidding process, are doing a good job keeping costs down. Monthly Medicare Advantage premiums are down 10 percent in 2016 from 2009 and this is a trend we think will continue.

2. **What impact do you expect Aetna's merger with Humana to have on consumers' choice of health plans?**

   Aetna's acquisition of Humana is about Medicare, a market that is robust and very competitive. In addition to having to compete with traditional Medicare, in the over 3,000 counties across the country, there are 143 health care companies offering Medicare Advantage plans, with an average of 18 Medicare Advantage private plan options available to each beneficiary. In California, Medicare beneficiaries have a choice of 21 plans on average in 2015. When combined, Aetna and Humana will be only about 8 percent of Medicare business nationwide, with 92 percent of Medicare beneficiaries having coverage other than Aetna or Humana.

   New entrants continue to enter Medicare Advantage. Twenty-eight new health plans have joined over the last 3 years, of which 15 are owned by providers. The trend of provider-based insurers in Medicare Advantage is continuing into the 2016 plan year. For example, Johns Hopkins recently announced it plans to offer a Medicare Advantage PPO featuring access to all of its providers, as well as thousands of others across Maryland.

Similarly, Cone Health, a two-hospital group based in Greensboro, NY, announced it will begin marketing a Medicare Advantage plan in 2016.

After the acquisition, the new Aetna will continue to face significant competition such as this from a large number of health plans and other new market entrants, including provider-based insurers — all of which will continue to offer consumers a robust selection of choices.

3. **What steps are you planning to take to ensure that it is easy for consumers to understand their exact provider network, especially if different plans offered by Aetna and Humana have different provider networks?**

   Both Aetna and Humana are committed to a consumer-centric model that includes offering health insurance products that are simple and easy to understand. This model includes providing simple tools that allow consumers to understand how to access the providers in their plan's network. At Aetna today, our DocFind web-based tool enables our members to locate and evaluate network providers and their services.

   Both Aetna and Humana are committed, pre- and-post transaction, to ensuring that consumers have all the information they need to choose health plans that best meet their needs — including clear and easy-to-use information about the providers in a plan's network.

4. **What impact do you expect Aetna's merger with Humana to have on the cost of premiums?**

   Aetna's acquisition of Humana is about Medicare. The primary goal is to enable us to offer more consumers a broader choice of products and access to higher quality, more affordable care.

   After the transaction, we expect to achieve over $1 billion in cost savings each year. We expect that a significant portion of these savings will flow back to consumers in the form of more cost-effective high quality product offerings in more areas across the country. Our goal is to remove waste and duplicative administrative costs and use some of the savings to develop products to keep people healthier.

   It is worth pointing out that Medicare Advantage plans, governed by the federal bidding process, are already doing a very good job keeping costs down for their members. Monthly Medicare Advantage premiums are down 10 percent in 2016 from 2009, and this is a trend we think will continue.

5. **What specific benefits to the consumer do you expect to see from Aetna's merger with Humana?**

   Aetna decided to acquire Humana to enable it to offer better and more innovative products, simplify insurance, and improve the overall health care experience for more

consumers. Following this transaction, Aetna consumers will have access to better consumer engagement, as well as programs and services that utilize particular Humana expertise. Our goal is to increase our customers' number of "Healthy Days", as measured by the Centers for Disease Control (CDC) metric.

Toward this goal, Humana is already a noted leader in delivering:

- Wellness and prevention programs (e.g., Humana Vitality, 12 percent lower health care costs and 15 percent lower absenteeism); and
- Home health care (Humana at Home — 496,000 more member days at home in 2014).

Meanwhile, Aetna is a leader in designing strong and dynamic relationships with high-quality providers. Examples of this include:

- Memorial Herman (Texas), where through improved efficiencies, costs have been lowered for the self-insured population from 2013 to 2014 by, increasing the generic prescribing rate by 21.3 percent and reducing avoidable emergency room visits by 13.5 percent.
- Banner Health (Arizona) where medical costs for commercial membership were reduced by five percent, along with a nine percent decrease in avoidable admissions.

Together, we will continue to accelerate these types of successes that benefit consumers. We will compete for business based on our ability to improve quality and cost, but we also want to win on effectively engaging consumers and delivering best-in-class service. In short, more consumers will have a broader choice of products, and access to higher quality and more affordable care.

6. **Are there any markets in which Anthem, Cigna, Aetna, and Humana each have more than 10% market share? If so, please identify them.**

Aetna is not in a position to speculate on Anthem and Cigna's market share. As for Aetna and Humana, calculating market shares is a complex, fact-intensive exercise and is a process we will likely work through with the Department of Justice as part of its investigation of Aetna's proposed acquisition of Humana.

Calculating shares requires a proper determination of relevant geographic and product markets. There are many distinct insurance products and the relevant geographic areas may vary based upon the insurance products or consumers involved. In the case of most products and geographies, there is little or no overlap between Aetna and Humana. Where the parties offer the same products in the same geography there are often numerous competitors.

Even where the parties offer the same product, however, Aetna and Humana tend to have different focuses. For example, in commercial insurance offered to employer groups, Aetna's business focuses on large multi-site self-insured customers whereas

Humana's business is focused on small fully-insured local employers. The transaction between Aetna and Humana combines companies that are highly complementary.

We also note that a 10 percent market share is not typically a cause for alarm from a competition perspective, and in the insurance industry, market shares typically are not a reliable indicator of a firm's competitive significance. Given the ability of employers and individuals customers to switch plans on an annual basis as well as the ability of insurance providers to take on new members, insurance providers can experience significant changes in enrollment numbers from year to year. From the perspective of employers and individual customers, the number of plans available to them is of greater competitive significance than any one firm's market share, and employers and individual customers in fact have a growing number of choices.

a. What impact do you expect the proposed mergers (i.e. Anthem with Cigna and Aetna with Humana) to have on consumers' choice of health plans in the markets in which the companies each have more than 10% market share?

Our deal is primarily about Medicare, as Humana has only two percent of the commercial market. Aetna's proposed acquisition of Humana will not negatively impact consumers' choice of health plans.

For example, over the last 3 years, 28 new companies began offering Medicare Advantage products. Ninety-four percent of Medicare beneficiaries already choose from at least five Medicare Advantage plan options, in addition to traditional Medicare. After this combination, Aetna-Humana will still only account for about eight percent of the total Medicare market.

In the commercial segment, there are a number of significant competitors, including United, Anthem, HCSC, Cigna, Highmark, Centene, CareFirst, other local Blue Cross Blue Shield plans, Emblem Health, Kaiser, and provider-based plans. Some of the largest and most prestigious health systems are entering the insurance business. On the eight public exchanges where Aetna and Humana both participate, there are on average 10 other insurers (at least 5 other participating issuers in each state). A growing number of employers also are turning to new private health care exchanges offered by large benefits consultants such as Towers Watson and Mercer.

b. What impact do you expect the proposed mergers (i.e. Anthem with Cigna and Aetna with Humana) to have on the cost of premiums in the markets in which the companies each have more than 10% market share?

The combined company will continue to face significant competition from a large number of competitors. The primary goal of the Humana transaction is to enable the combined company to offer consumers a broader choice of products and access to higher-quality and more-affordable care. Also, bringing together Aetna and Humana is projected to realize over $1 billion of synergies in 2018 and each year thereafter —

which will enable us to drive costs out of the system and offer more affordable products to our consumers.

The combination will enhance our ability to work with providers and create value-based payment agreements that result in better care to consumers. Our combined organization will build a health services division that will offer consumers and providers digital solutions and services that will lower costs and improve care.

Given that our merger is primarily about Medicare, it is important to note that Medicare is tightly regulated to protect consumers. Most notably, in Medicare Advantage, companies bid against government determined benchmarks and operate within regulated profit limits.

Questions for the Record from Senator Thom Tillis for Mark T. Bertolini

1. **What can Congress do to ensure that the United States Department of Justice objectively examines these proposed mergers, free from undue influence from the Administration, and without predetermining the outcome of their analysis?**

   The July announcement of the Aetna acquisition of Humana is the first step in a process that is subject to both federal and state review. Over the next several months, we will cooperate with the appropriate regulators to answer their questions as they review the transaction. We are confident the Department of Justice will conduct a thorough and detailed review.

2. **Much has been said of the potential ability of larger health insurers to act as a check on larger provider networks. In short, the argument goes that larger insurers can better negotiate with larger provider chains, thus creating a balance that will ultimately benefit consumers. Do you agree with this justification?**

   Aetna's acquisition of Humana is about Medicare. The primary goal is to enable us to offer more consumers a broader choice of products and access to higher quality, more affordable care.

   We do not view the transaction as a way to negotiate better rates. Rather, we think the combination will enhance our ability to work with providers and create value-based payment agreements that result in better care to consumers. In fact, as we move away from the rate negotiations of the old days to value-based care arrangements with providers, we find that by putting the right incentives in place, we and our provider partners end up sharing the same goal of improving health care at a reduced cost.

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

   Further, do you believe that consolidation in the health insurance market is the inevitable result of consolidation in the provider market?

   There has been much research linking provider consolidation to increased healthcare spending.

   In our transaction, Aetna and Humana are combining to enhance our ability to work with providers to create value-based payment arrangements that result in better care to consumers.

One successful example of these arrangements is Innovation Health, an insurance product offered by Aetna and Inova in Virginia. Together we offer consumers premiums that are three to five percent lower than other network plans in the area. And we've improved health outcomes, including a 27 percent reduction in C-section admissions and 86 percent engagement in complex case management.

A combined Aetna and Humana will still occupy only eight percent of the Medicare marketplace.

Finally, please opine as to whether the Affordable Care Act has hastened consolidation in health care markets, and if so, identify the features of the Act that are most responsible for this result.

The Affordable Care Act has accelerated changes (some of which were already occurring) and has influenced all elements of the health care system over the past few years. That being said, the primary goal of the Humana transaction is to enable us to offer more consumers a broader choice of products and access to higher quality, more affordable care.

Our decision to acquire Humana was based on what we believe is in the best interest of our customers, offering them more healthy days per year by building a consumer centric health care experience.

Questions for the Record from Senator David Vitter for Mark T. Bertolini

Background:

The ACA's medical loss ratio (MLR) requirement mandates that insurers spend at least 85 percent of premium revenues for large groups on claims or "activities that improve health care quality." In doing so, the MLR shields incumbents from competition. The need for sufficient scale to comply with MLRs is an impediment to start-up insurance providers while, at the same time, mergers of existing insurers is incentivized by the requirement to minimize administrative and operating costs as a percentage of revenue.

MLRs are also likely to limit the capacity of small insurers to invest in overhead needed to expand, serving as punishment for retaining funds unused for medical expenses, which, in turn, is likely to make external funding necessary.

Caps on operating expenses can also work to the advantage of hospital run health plans, where the cap is set at 20% of revenue. On the other hand, the cap on operating expenses for for-profit health insurers is set at 15%. This variance gives an advantage to hospital run health plans, which have an easier time staying under the cap because they can shift costs between medical care and administrative overhead. For-profit health insurers, since the provision on medical care is not an option, must spread their fixed operating costs over a larger base of members in order to sustain themselves while meeting the government imposed caps. They must grow larger through mergers and acquisitions.

Questions Addressed to Each of the Witnesses:

1. **What role do the ACA's medical loss ratio requirements play in calculations and decisions of health insurers to consolidate? Does the cap on operating expenses incentivize scale over competition, driving insurance industry consolidation?**

   Aetna's acquisition of Humana is about Medicare. Our decision to acquire Humana was not driven by the medical loss ratio (MLR). Rather, the goal of our transaction is to enable us to offer more consumers a broader choice of products and access to higher quality, more affordable care.

2. **Do MLRs make market competition-driving high deductible health plans harder to provide, forcing insurers to avoid markets with greater moral hazard that may also have a greater need for higher administrative costs?**

   Current MLR rules can present challenges for issuers of high-deductible health plans (HDHPs), because of fixed expenses such as marketing and enrollment, that do not vary by how lean or rich the benefits are. So for a HDHP, those fixed expenses represent a higher percentage of claims and premiums than a lower-deductible plan.

Nevertheless, Aetna continues to offer HDHPs for our customers interested in health savings accounts (HSAs) and related savings vehicles, a market that continues to grow and to which Aetna remains committed.

3. **Does this lack of competition result in higher health care costs for consumers? Will it do so in the future?**

Aetna's acquisition of Humana is about Medicare, a market that is robust and very competitive. Aside from having to compete with traditional Medicare, in the over 3,000 counties across the country, there are 143 health care companies offering Medicare Advantage plans. New entrants continue to come into Medicare Advantage. Twenty-eight new health plans have joined over the last 3 years and beneficiaries have an average of 18 Medicare Advantage private plan options to choose from; even in non-metro (more rural) areas there is an average of 10 plan options to choose.

As noted above, the MLR is clearly a part of the regulatory landscape (including in Medicare Advantage) and it does bring associated compliance costs. And overall, the MLR also can also sometimes present a challenge to carriers seeking to reduce costs and innovate. However, in our experience, the MLR has not significantly compromised our ability to compete and to deliver savings to our customers through competitive pricing of quality products.

With respect to the Medicare Advantage program more broadly, Medicare Advantage plans, governed by the federal bidding process, are doing a good job keeping costs down. Monthly Medicare Advantage premiums are down 10 percent in 2016 from 2009.

Question for the Record from Senator Orrin Hatch for Mark T. Bertolini:

1. **The American Hospital Association has argued that the Aetna-Humana merger would increase the Herfindahl-Hirschman Index score for Medicare Advantage by over 200 points in 924 highly concentrated markets and by over 100 points in another 159 highly concentrated markets. Do you agree with those calculations? If not, why not? And if those calculations are correct, does that mean the merger will presumptively increase market power?**

   We recognize the provider trade associations in Washington, D.C. have expressed concerns about this deal. The AHA and AMA are large membership organizations that represent a diverse set of interests. But we have a different perspective, all health care is local. Aetna's acquisition of Humana is about Medicare, a market that is robust and full of competition. In fact, we believe these concerns are unfounded.

   Aetna has a track record of working in collaboration with dozens of forward-looking hospital systems and doctor groups to create better products for consumers based on value-based design. Many of these partners are likely members of the trade associations that have expressed concerns. In these partnerships, together, we align financial incentives to improve cost and quality for the population served.

   For example, Innovation Health in Virginia is an insurance plan offered by Aetna and Inova Health System. Our membership quadrupled in 2014 and we have been able to offer premiums that are three to five percent lower than other network plans in the area. We have improved health outcomes too, including a 27 percent reduction in C-section admissions and 86 percent engagement in complex case management.

   Similarly, Aetna's collaborations with the Memorial Herman Accountable Care Organization in Houston, Texas and Banner Health Network in Mesa, Arizona have also led to positive results including consistent membership growth — showing that this type of care model and health plan is resonating — and cost and quality improvements.

   As for the Herfindahl-Hirschman Index (HHI) scores estimated by the AHA, they require proper definition of geographic markets and product markets. This is a complicated process that we continue to work through with the Department of Justice. And even when HHIs are accurately calculated, they are a screening mechanism, and not determinative. The HHI screens create a safety zone, below which there are not likely to be any issues. If a transaction is above the screen, a more thorough analysis of documents, market facts, competitors, new entrants, products, geographies, costs, prices, innovation, and efficiencies, among other things, is necessary.

   Together, Aetna and Humana would have only 8 percent of all Medicare enrollment and 13 percent of all commercial enrollment once the transaction is complete. While I am confident competition will remain strong, even after our transaction, I would leave the detailed analysis and thorough review to the Department of Justice.

Question for Joseph R. Swedish, President & CEO, Anthem, Inc.

1. **The American Hospital Association has argued that the Anthem-Cigna merger would increase the Herfindahl-Hirschman Index score for commercial health insurance by over 200 points in 600 highly concentrated markets and by over 100 points in another 217 highly concentrated markets. Do you agree with those calculations? If not, why not? And if those calculations are correct, does that mean the merger will presumptively increase market power?**

   This question was not directed to Aetna.

Questions for the Record from Senator Patrick Leahy for Mark T. Bertolini

1. **Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the reauthorization process.**

   Do you continue to support the permanent antitrust exemption for the health insurance industry? If so, what justification can you give this Committee for why it should continue to exist, and in particular, why it should exist on a permanent basis?

   While we understand the need to examine antitrust exemptions to see if they continue to serve the public interest, McCarran-Ferguson does not prevent the antitrust laws from being applied to our merger. Aetna does not believe that the McCarran-Ferguson Act, which provides an antitrust exemption for the "business of insurance," prevents or hinders the Department of Justice from investigating the antitrust implications of Aetna's proposed acquisition of Humana. The exemption under the Act is limited in many ways and the Department of Justice has investigated and brought many antitrust actions involving insurance providers in the past. We are complying with the Department of Justice's request for information regarding the Humana transaction.

Question for the Record for Joseph Swedish

1. **Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the reauthorization process.**

   Do you continue to support the permanent antitrust exemption for the health insurance industry? If so, what justification can you give this Committee for why it should continue to exist, and in particular, why it should exist on a permanent basis?

   This question was not directed to Aetna.

Question for the Record for Paul Ginsburg

1. **Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the**

reauthorization process.

Is there any justification for leaving this permanent antitrust exemption in place in its current form?

This question was not directed to Aetna.

2. **Are there any concerns that you raised with respect to these particular mergers that could be exacerbated by leaving the permanent health insurance industry antitrust exemption in place?**

This question was not directed to Aetna.

Question for the Record for Leemore Danfy

1. **Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the reauthorization process.**

Is there any justification for leaving this permanent antitrust exemption in place in its current form?

This question was not directed to Aetna.

2. **Are there any concerns that you raised with respect to these particular mergers that could be exacerbated by leaving the permanent health insurance industry antitrust exemption in place?**

This question was not directed to Aetna.

Question for the Record for Richard Pollack

1. **Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the reauthorization process.**

Is there any justification for leaving this permanent antitrust exemption in place in its current form?

This question was not directed to Aetna.

2. **Are there any concerns that you raised with respect to these particular mergers that could be exacerbated by leaving the permanent health insurance industry antitrust exemption in place?**

   This question was not directed to Aetna.

Question for the Record for George Slover

1. **Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the reauthorization process.**

   Is there any justification for leaving this permanent antitrust exemption in place in its current form?

   This question was not directed to Aetna.

2. **In your view, what would be the impact on consumers if the permanent antitrust exemption for the health insurance industry is kept in place during a period of industry consolidation?**

   This question was not directed to Aetna.

Questions for the Record from Senator Mike Lee for Mark T. Bertolini

1. **Should your acquisition of Humana receive clearance from the Department of Justice and be consummated, will your customers see an increase or decrease in their premiums, deductibles, and/or co-pays?**

   Aetna's acquisition of Humana is about Medicare. The primary goal of the Humana transaction is to enable us to offer more consumers a broader choice of products and access to higher quality, more affordable care.

   After the transaction, we expect to achieve over $1 billion in cost savings each year. We expect that a significant portion of these savings will flow back to consumers in the form of more cost-effective high quality products offerings in more areas across the country. Our goal is to remove waste and duplicative administrative costs and use some of the savings to develop products to keep people healthier.

   We think it is worth noting that Medicare Advantage plans, governed by a federal bidding process, are already doing a good job keeping costs down. Monthly Medicare Advantage premiums are down 10 percent in 2016 from 2009 and this is a trend we think will continue.

2. **In your testimony, you mentioned pursuing greater affordability and higher quality for your health insurance products. What do you mean by "affordability," and what do you mean by "quality?"**

   Aetna decided to acquire Humana to enable us to offer better and more innovative products, simplify insurance, and improve the overall health care experience for more consumers. Consumers will have access to better consumer engagement, programs and services that utilize Humana expertise. Our goal is to increase our customers' number of "Healthy Days", as measured by the CDC metric. For example:

   Humana is a leader in delivering better care at a lower cost. For example:

   - Wellness and prevention programs (e.g., Humana Vitality, 12 percent lower health care costs and 15 percent lower absenteeism); and
   - Home health care (Humana at Home — 496,000 more member days at home in 2014)

   Meanwhile, Aetna is a leader in designing strong and dynamic relationships with high quality providers, including:

   - Memorial Herman (Texas), where through improved efficiencies, costs have been lowered for the self-insured population from 2013 to 2014 by, increasing the generic prescribing rate by 21.3 percent and reducing avoidable emergency room visits by 13.5 percent.

- Banner Health (Arizona) where medical costs for commercial membership were reduced by five percent, along with a nine percent decrease in avoidable admissions.

We will continue to compete on improved quality and cost but also want to win on consumer engagement. In short, more consumers will have a broader choice of products, access to higher quality and more affordable care.

3. **In explaining why your merger with Humana is necessary to achieve the efficiencies and consumer benefits you expect, you identified the portability of health insurance plans and the need to enter new markets quickly and broadly in order to do so effectively. How does this square with your repeated assertion that "health care is local?"**

Health care is local and what matters most to consumers are the plan options and providers available to them in their areas. Nowhere is this more evident than Medicare, where Medicare Advantage plans compete against traditional fee-for-service Medicare and each other in over 3,000 counties across the country. There are 143 health care companies offering Medicare Advantage plans, with new entrants coming into Medicare Advantage. Twenty-eight new health plans have joined over the last 3 years and beneficiaries have an average of 18 Medicare Advantage private plan options to choose from; even in non-metro (more rural) areas there is an average of 10 plan options to choose.

At the local level, providers are also starting their own health plans. For example, in Medicare Advantage of the 28 new entrants coming into the market over the last 3 years, 15 are owned by providers. This trend is continuing into the 2016 plan year — Johns Hopkins just announced it will offer a PPO with access to all of its providers, as well as thousands of others across Maryland. Similarly, Cone Health, a two-hospital system based in Greensboro, NY, recently announced that it will begin marketing a Medicare Advantage plan in 2016.

Our proposed transaction brings together Aetna and Humana's complementary capabilities in the highly competitive Medicare and commercial product segments, while diversifying Aetna's portfolio. Aetna's experience will make Humana's commercial business more effective and competitive. Similarly, Humana's capabilities will make Aetna's Medicare business more effective and competitive by allowing Aetna to offer Humana's award-winning care and service model to the rapidly growing Medicare population. In this way, the transaction will enable the combined company to enter new markets quicker and more effectively than either company could do separately.

Over the first three years of the transaction, we expect to achieve over $1 billion in cost savings each year that will help Aetna become more efficient and provide high quality affordable products. We expect that a significant portion of these savings will flow back to consumers through more cost-effective products. Our goal is to remove waste and duplicative administrative costs and use some of the savings to develop products to keep people healthier.

4. **In addition, does not this imply that there are significant barriers to entry in these markets?**

   We do not believe there are barriers to entry in the current environment. We think the combination of Aetna and Humana will actually enhance competition at the local level by giving consumers a strong alternative to Blue Cross Blue Shield plans and other competitors.

   In this way, this combination is actually strongly pro-competitive. Even after the acquisition, Aetna will continue to face significant competition from a large number of health plans and other new market entrants such as Accountable Care Organizations (ACOs) or start-up companies like Oscar. Oscar, which recently received additional investment from Google, has built a successful new model with a consumer-centric approach is focused on providing insurance through the exchanges in New York and New Jersey and plans to expand to other states.

   There has also been a rapid increase in provider-sponsored health plans, for example, in Medicare Advantage of the 28 new entrants coming into the market over the last 3 years, 15 are owned by providers. This trend is continuing into the 2016 plan year — Johns Hopkins just announced it will offer a PPO with access to all of its providers, as well as thousands of others across Maryland. Similarly, Cone Health, a two-hospital system based in Greensboro, NY, recently announced that it will begin marketing a Medicare Advantage plan in 2016. Further, Medicaid managed care plans, such as Centene, are expanding into Medicare Advantage and commercial business.

   Nationally, there are over 400 insurance companies in the commercial market. The most recent Government Accountability Office (GAO) report on state-level concentration in commercial health insurance indicates that, from 2010 – 2013, a Blue Cross Blue Shield insurer was the largest insurer in 44 states in the individual market, 38 states in the small group market, and 40 states in the large group market. Meanwhile, Aetna was the largest insurer in only one area (DC large group), and Humana was not the largest insurer in the commercial market in any area.

   We anticipate the transaction will enhance competition in the public exchanges as well, where options are increasing for eligible enrollees. On July 27, 2015, the Department of Health & Human Services (HHS) announced that 86 percent of individuals eligible to enroll in the exchanges had access to at least 3 issuers in 2015, up from 70 percent in 2014. Nearly 60 percent of counties experienced a net gain of at least one issuer, while only 8 percent of counties experienced a net loss of issuers.

5. **What are the product and geographic market overlaps between your business and Humana's, and what is your company willing to do to address them?**

   Identifying and measuring the extent of any product or geographic overlap between Aetna and Humana is a complex, fact-intensive exercise and is a process we will work

through with the Department of Justice as part of its investigation of Aetna's proposed acquisition of Humana. There are many distinct insurance products and the relevant geographic areas of overlap may vary based upon the insurance products or consumers involved.

In the case of most products and geographies, there is little or no overlap between Aetna and Humana. Where the parties offer the same products in the same geography there are often numerous competitors. Even where the parties offer the same product, Aetna and Humana tend to have different focuses. For example, in commercial insurance offered to employer groups, Aetna's business focuses on large multi-site self-insured customers whereas Humana's business is focused on small fully-insured local employers. The transaction between Aetna and Humana combines companies that are highly complementary.

The combined company will continue to face significant competition from a large number of competitors. Employers and individual customers have a growing number of choices. This deal is primarily about Medicare and in the Medicare Advantage market there 143 companies offering plans in 2015. And more companies are entering this market each year. In Medicare Advantage of the 28 new entrants coming into the market over the last 3 years, 15 are owned by providers. Ninety-four percent of Medicare beneficiaries already choose from at least five Medicare Advantage plan options, in addition to traditional Medicare. After this combination, Aetna-Humana will still only account for about eight percent of the total Medicare market.

Humana represents less than 2 percent of the commercial market and Aetna less than 12 percent. The commercial market will remain basically unchanged after the transaction. In the commercial segment, there are a number of significant competitors, including United, Anthem, HCSC, Cigna, Highmark, Centene, CareFirst, other local Blue Cross Blue Shield plans, Emblem Health, Kaiser, and provider-based plans. Some of the largest and most prestigious health systems are entering the insurance business. On the 8 public exchanges where Aetna and Humana both participate, there are on average 10 other insurers (at least five other participating issuers in each state). A growing number of employers also are turning to new private health care exchanges offered by large benefits consultants such as Towers Watson and Mercer.

This transaction is subject to a lengthy, careful and thorough investigation by the Department of Justice and State Attorneys General. As the analysis continues to develop, if necessary, we are amenable to discussing appropriate remedies to resolve potential competitive concerns.

6. **As I'm sure you're aware, federal regulations and legislation have imposed a complex set of restrictions and requirements upon your business. Between actuarial value measures, community rating, age bands, guaranteed issue, and medical loss ratios, how does your business set itself apart from the competition?**

   Whether it's the Affordable Care Act, the Medicare Prescription Drug benefit, or another government program, our job is to follow the law and provide affordable, high quality, health products to consumers.

   The health care industry is rapidly transforming amid a highly competitive environment where a number of new companies have entered the market, providing consumers with more choice than ever before. As a result of these industry-wide changes, a new economic model is emerging for health insurers.

   Competing on price alone is no longer enough. Instead, consumer engagement will be key, especially as more individuals move from employer-based insurance to the individual market, where the consumer will determine where and how to access the health care system. We believe that to be successful, insurers will need to compete on price, but will win on how effectively they engage consumers to help keep them healthy and make it easier to navigate the health care system.

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

   Together, we will be better positioned to deliver a consumer-centric experience and when it comes time to re-enroll customers decide to choose Aetna because they experienced superior best-in-class service.

Question for the Record for Joseph Swedish:

1. **Should your acquisition of Cigna receive clearance from the Department of Justice and be consummated, will your customers see an increase or decrease in their premiums, deductibles, and/or co-pays?**

   This question was not directed to Aetna.

2. **In your testimony, you mentioned pursuing greater affordability and higher quality for your health insurance products. What do you mean by "affordability," and what do you mean by "quality?"**

   This question was not directed to Aetna.

3. **In explaining why your merger with Cigna is necessary to achieve the efficiencies and consumer benefits you expect, you identified the length of time it would take to enter markets individually, as opposed to all-at-once through the acquisition, and constantly changing consumer demand as reasons for the deal. Are not these concerns significant barriers to entry for potential competitors?**

   This question was not directed to Aetna.

4. **What are the product and geographic market overlaps between your business and Cigna's, and what is your company willing to do to address them?**

   This question was not directed to Aetna.

5. **As I'm sure you're aware, federal regulations and legislation have imposed a complex set of restrictions and requirements upon your business. Between actuarial value measures, community rating, age bands, guaranteed issue, and medical loss ratios, how does your business set itself apart from the competition?**

   This question was not directed to Aetna.

6. **Do you believe there is a national market for commercial health insurance plans, ASO plans, or any other product? If so, how will Anthem and Cigna's merger effect competition in those markets?**

   This question was not directed to Aetna.

Question for the Record for Leemore Dafny:

1. **Defenders of the Aetna/Humana and Anthem/Cigna mergers have identified several new entrants in the health insurance industry as evidence of the ease and likelihood of entry. What is your view of these entrants? Do they actually compete with the merging parties? Are they likely to impose any competitive restraint on them? Are they likely to survive long-term?**

   This question was not directed to Aetna.

2. **Utah is home to strong regional competition in the health insurance space, especially from companies such as Intermountain Healthcare/SelectHealth. Do you believe the proposed mergers may result in lower payments to providers, which the providers may seek to cost-shift to such regional health plans?**

   This question was not directed to Aetna.

Question for the Record for Paul Ginsburg:

1. **Defenders of the Aetna/Humana and Anthem/Cigna mergers have identified several new entrants in the health insurance industry as evidence of the ease and likelihood of entry. What is your view of these entrants? Do they actually compete with the merging parties? Are they likely to impose any competitive restraint on them? Are they likely to survive long-term?**

   This question was not directed to Aetna.

2. **Utah is home to strong regional competition in the health insurance space, especially from companies such as Intermountain Healthcare/SelectHealth. Do you believe the proposed mergers may result in lower payments to providers, which the providers may seek to cost-shift to such regional health plans?**

   This question was not directed to Aetna.

Question for the Record for George Slover:

1. **What is your view of the necessity for the parties to merge in order to realize the benefits and efficiencies they claim will result from the transactions?**

   This question was not directed to Aetna.

2. **How do consumers view "affordability" and "quality" when shopping for health insurance? What do consumers value when selecting a health insurance plan?**

   This question was not directed to Aetna.

Senator Lee

1) Defenders of the Aetna/Humana and Anthem/Cigna mergers have identified several new entrants in the health insurance industry as evidence of the ease and likelihood of entry. What is your view of these entrants? Do they actually compete with the merging parties? Are they likely to impose any competitive restraint on them? Are they likely to survive long-term?

Ginsburg Response:

New entrants with the greatest potential to compete with the merging parties are the large health systems that are either creating their own health plans or creating health plan products in collaboration with an insurer. The shift towards more limited networks has created a more attractive environment for such plans in which networks are limited to the health care system's circle of providers. The trend towards public and private insurance exchanges is also making this type of entry into insurance markets more feasible. Entry of large health systems into the Medicare Advantage market will also be important. This will be relevant to the Aetna-Humana merger. It is less relevant to Anthem-Cigna, where the competitive concerns are mostly in the national market for large self-insured employers, where plans associated with health systems are likely to be less important.

I do not see the newly formed Co-op plans as a significant threat to compete with the merging parties.

2) Utah is home to strong regional competition in the health insurance space, especially from companies such as Intermountain Healthcare/SelectHealth. Do you believe the proposed mergers may result in lower payments to providers, which the providers may seek to cost-shift to such regional health plans?

Ginsburg Response:

Intermountain Healthcare/SelectHealth is a good example of the phenomenon that I was discussing in response to your first question.

Insurer mergers do lead to lower prices to providers, although this will not apply to prices to hospitals in the Medicare Advantage market due to the presence of the traditional Medicare program as an alternative for beneficiaries and Medicare regulations on balance billing. But outside of Medicare Advantage, I do not see lower rates from the merging parties leading to higher rates charged to other insurers. The recent research literature on hospital cost shifting, which is focused on reactions to changes in Medicare payment rates to hospitals, suggests that hospitals respond to lower rates from Medicare by reducing their costs, which leads to lower rates charged private insurers. While economists are not all in agreement about hospital cost

shifting, although the recent research I mentioned might change that, I not aware of any who believe in physician cost shifting.

Senator Vitter

1. What role do the ACA's medical loss ratio requirements play in calculations and decisions of health insurers to consolidate? Does the cap on operating expenses incentivize scale over competition, driving insurance industry consolidation?

Ginsburg Response:

I believe that medical loss ratios are playing a role in decisions of health insurers to consolidate. This may lead to less competition among insurers. In a sense, the MLR restrictions are substituting regulation for competition. That does not necessarily make them the wrong policy. The issue is which is more effective at lowering premiums for the purchasers of insurance. If insurance markets are not that competitive, restrictive MLRs could lead to lower premiums for consumers. Rural areas are examples of where there tends not to be much insurer competition.

2. Do MLRs make market competition-driving high deductible health plans harder to provide, forcing insurers to avoid markets with greater moral hazard that may also have a greater need for higher administrative costs?

Ginsburg Response:

MLR regulations are more constraining for high-deductible products because the medical losses are lower while the administrative costs are roughly the same. This is one of the areas where the current approach to MLRs may be too blunt. Perhaps the minimums need to be varied according to actuarial value. Another difficult area is administrative costs devoted to managing chronic disease. We do not want to restrain resources going into ensuring better care for those with chronic diseases.

3. Does this lack of competition result in higher health care costs for consumers? Will it do so in the future?

Ginsburg Response: Possible reduction in competition needs to be weighed against what MLR regulations can accomplish in areas where competition is not sufficient.

Senator Tillis

Question 1:

What can Congress do to ensure that the United States Department of Justice objectively examines these proposed mergers, free from undue influence from the Administration, and without predetermining the outcome of their analysis?

Ginsburg Response: This hearing and others like it are the most effective way for Congress to achieve these objectives. Such hearings increase the public's awareness of issues and engagement, which in turn makes departing from an objective analysis more costly. But it is inevitable that the perspective of the Administration will play a role.

Question 2:

Much has been said of the potential ability of larger health insurers to act as a check on larger provider networks. In short, the argument goes that larger insurers can better negotiate with larger provider chains, thus creating a balance that will ultimately benefit consumers.

Do you agree with this justification?

Ginsburg Response: More concentration in insurance markets does lead to lower prices paid to providers. When insurance markets are competitive enough, this will likely benefit consumers. But when the markets are not competitive enough, the benefits will not be passed on to consumers. So review of insurer mergers is important, but the potential for lower provider process should have some influence on the review.

Further, do you believe that consolidation in the health insurance market is the inevitable result of consolidation in the provider market?

Ginsburg Response: I am not sure. To the degree that increased provider consolidation increases the difference in rates charged to insurers of different sizes, that might increase what insurance mergers can accomplish. But I have not seen any data on whether that is the case. I do not see provider consolidation as an important factor behind the two mergers that the Subcommittee examined at its hearing.

Finally, please opine as to whether **the Affordable Care Act has hastened consolidation in health care markets**, and if so, identify the features of the Act that are most responsible for this result.

Ginsburg Response: It has had some impact. The most controversial portions of the ACA—tax credits for private insurance and Medicaid expansion—have not increased consolidation in a significant way. Indeed the market for individually-purchased insurance has become more competitive as a result of the pubic exchanges and the structure of tax credits.

Some of the less controversial provisions may be leading to more provider consolidation. For example, Medicare's initiatives to promote alternative payment approaches such as accountable care organizations and bundled payment, which have a great deal of potential to increase efficiency and quality, have increased provider motivations to become larger to be able to engage in these arrangements.

Senator Leahy:

Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the reauthorization process.

Is there any justification for leaving this permanent antitrust exemption in place in its current form?

Are there any concerns that you raised with respect to these particular mergers that could be exacerbated by leaving the permanent health insurance industry antitrust exemption in place?

Ginsburg Response: The McCarran-Ferguson Act exempts the "business of insurance" from federal anti-trust law, but does not exempt the companies. So the Justice Department is appropriately reviewing the two mergers under discussion at this hearing. Some states have applied their own anti-trust laws to insurers. From what I have read over the years on this issue, it appears that health insurers now get little benefit from this exemption. So repealing it would not have much impact on insurers or on the public.

Questions for the Record
Richard J. Pollack, President and CEO, American Hospital Association
U.S. Senate Judiciary Committee
Subcommittee on Antitrust, Competition Policy and Consumer Rights
"Examining Consolidation in the Health Insurance Industry and its Impact on Consumers"
September 22, 2015

In response to Senator Vitter's questions

1. What role do the ACA's medical loss ratio (MLR) requirements play in calculations and decisions of health insurers to consolidate?

Answer: See the attached fact sheet, "Why Medical Loss Ratio Requirements Aren't a Defense to Further Health Plan Consolidation."

Does the cap on operating expenses incentivize scale over competition, driving insurance industry consolidation?

Answer: No.

2. Do MLRs make market competition-driving high deductible health plans harder to provide, forcing insurers to avoid markets with greater moral hazard that may also have a greater need for higher administrative costs?

Answer: No.

3. Does this lack of competition result in higher health care costs for consumers? Will it do so in the future?

Answer: Yes. A lack of competition does result in higher health care costs for consumers and will impact them now and in the future. As Professor Leemore Dafny noted in her testimony at this hearing, claims of offsetting efficiencies cannot ameliorate the competitive harm from this deal. "Efficiencies must be merger-specific and verifiable...and there is still the question of whether benefits will be passed through to consumers in light of that diminished competition" (p. 16). Professor Dafny also noted that insurance "consolidation that occurs now is unlikely to be undone if it later proves anticompetitive," as most expect it will (p. 3).

Insurers have a dismal track record of passing any savings from an acquisition on to consumers, and there is no reason to believe that this transaction would be any different (testimony of Professor Thomas L. Greaney, Before the House of Representatives Subcommittee on Regulatory Reform, Commercial and Antitrust Law, September 10, 2015).

With respect to the Medicare Advantage (MA) market, there is already an almost complete lack of competition, according to an August 2015 report by the Commonwealth Fund, which found that 97 percent of MA markets in U.S. counties are "highly concentrated." This confirms the findings of a recent report by the Kaiser Family Foundation (Medicare Advantage 2015 Spotlight: Enrollment Market Update, June 30, 2015) that also described MA markets as highly concentrated. That report also noted that, while the MA program has continued to grow in virtually all states, MA plans now provide less financial protection for enrollees and average out-of-pocket expenses have continued to climb; this is not an unexpected development in such highly-concentrated markets.

In response to Senator Tillis's questions

Much has been said of the potential ability of larger health insurers to act as a check on larger provider networks. In short, the argument goes that larger insurers can better negotiate with larger provider chains, thus creating a balance that will ultimately benefit consumers.

1. Do you agree with this justification?

Answer: No. As Professor Leemore Dafny noted in her testimony at this hearing, claims of offsetting efficiencies cannot ameliorate the competitive harm from this deal. "Efficiencies must be merger-specific and verifiable…and there is still the question of whether benefits will be passed through to consumers in light of that diminished competition" (p. 16).

2. Further, do you believe that consolidation in the health insurance market is the inevitable result of consolidation in the provider market?

Answer: No. The seeming underlying business case for the insurance companies to consolidate – increasing "top-line" revenues and profits through acquisition rather than competition without offsetting demonstrable efficiencies – is fundamentally different than that for transactions in the hospital sector. The hospital sector is undergoing profound structural changes, driven by the need to take on risk as the field moves away from fee-for-service payments toward population health, offers integrated clinical care and provides financially failing facilities with the resources they require to survive and continue to serve their communities. Yet despite those pressures, the growth in hospital spending is at historic lows, which is entirely inconsistent with claims from commercial insurers about the impact of hospital transactions (Bureau of Labor Statistics Producer Price Index data, 2014-2015, for Hospitals (622)).

3. Finally, please opine as to whether the Affordable Care Act has hastened consolidation in health care markets, and if so, identify the features of the Act that are most responsible for this result.

Answer: The ACA is only one of many forces that are spurring realignment in the hospital field. The effort to replace a "siloed" health care system with a continuum of care is driven by the

hospital field and widely supported by both the government and private sector, as well as consumers. The effort to build a continuum has led to hospitals looking to join with other facilities, medical staff and others to improve quality and efficiency and adapt to new payment methods predicated on value.

Hospitals also are dealing with new competitors such as pharmacies, discount retailers and technology giants. This requires hospitals to be more nimble in reaching patients in the community where they live, not just an institutional setting. If hospitals are to successfully respond to these market forces, as well as government demands, they will have to do so by aligning with other hospitals and physician practices, often through mergers and acquisitions. While the antitrust agencies downplay this challenge, decades-old regulatory barriers still keep hospitals and doctors from working together when the physicians are not employed by the hospital. Real alignment to deliver population-based care takes the kind of commitment that only a fully integrated health care system can deliver.

In response to Senator Leahy's questions

Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the reauthorization process.

1. Is there any justification for leaving this permanent antitrust exemption in place in its current form?

Answer: No.

2. Are there any concerns that you raised with respect to these particular mergers that could be exacerbated by leaving the permanent health insurance industry antitrust exemption in place?

Answer: As long as the McCarren-Ferguson exemption exists, insurers, including Anthem, Cigna, Aetna and Humana, will use it as a defense to anticompetitive conduct. The insurer raised it unsuccessfully when the United States sued Michigan Blue Cross Blue Shield for anticompetitive practices related to its use of most favored nation clauses to discourage entry by other insurers into the market (*U.S. et al., v. Blue Cross Blue Shield of Michigan*). In addition, they could claim that premium pricing and market allocation are protected (see statement of Christine A. Varney, Assistant Attorney General, Antitrust Division, DOJ, before the Senate Judiciary Committee, October 14, 2009, at 2-3, "It is fair to say that the McCarran-Ferguson Act antitrust exemption is very expansive with regard to anything that can be said to fall within 'the business of insurance,' including premium pricing and market allocation"). If so, this could allow for coordinated conduct, such as price fixing or market allocation agreements, among the few large national competitors that remain if these deals are permitted to go forward. The result for

consumers would be higher prices and fewer benefits, as well as reduced access to services, longer wait times and other unfortunate likely consequences of these deals.

Why Medical Loss Ratio Requirements Aren't a Defense to Further Health Plan Consolidation (Commercial Market)

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

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

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

Moreover, the ACA's MLR standards are not applied to all health coverage. The federal government estimated in 2010 that the MLR standards would protect up to 74.8 million insured Americans,[4] which was less than 40 percent of people with private health insurance that year.[5] Plans that are not subject to the MLR requirements include those that are fully- or partially self-insured, which comprise well over 50 percent of private sector employees. Also exempt are dental-only, accident-only and other "excepted benefits," as well as expatriate plans. In addition, a one-year deferral from the MLR is available to insurers that would otherwise be subject to the MLR limits but have a high proportion of new plans (representing at least half of their business in a given state). [6]

Why the MLR Doesn't Support Further Health Plan Consolidation. The MLR requirements have already surfaced as a defense to the proposed acquisitions of Cigna by Anthem and of Humana by Aetna. The argument to the Department of Justice's Antitrust Division (DOJ) and other federal and state regulators would be that the insurers are constrained from raising prices to

consumers because of the MLR margin (profit or net revenue) restrictions applicable in both the commercial and Medicare Advantage markets. This argument is unavailing and should be rejected for the several principle reasons:

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

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

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

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

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

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

A. Plan is at MLR in Time 1

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

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

B. Plan is above minimum MLR in Time 1

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

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

C. Plan is below minimum MLR in Time 1

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

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

	Time 1	Time 1 Loss Ratio	Time 2	Time 2 Loss Ratio
Premium	$1,000		$1335	
Payments for medical claims and quality activities	$800	75%	$1,135	85%
All other expenses	$200		$200	

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

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

[2] McCue, Michael J. and Mark A. Hall, The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 3, The Commonwealth Fund, March 2015; http://www.commonwealthfund.org/~/media/files/publications/issuebrief/2015/mar/1808_mccue_med_loss_ratio_year_3_rb.pdf?la=en

[3] Mark Farrah Associates, *Enrollment Gains and Favorable Profits for Health Insurance Leaders in 2014,* May 15,2015, http://www.markfarrah.com/healthcare-business-strategy/Enrollment-Gains-and-Favorable-Profits-for-Health-Insurance-Leaders-in-2014.aspx

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

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

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

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

[8] These rates are rounded to the nearest full percentage. AHRQ, Medical Expenditure Panel Survey, Table II.B.2.b.(1)(2014) Percent of private-sector enrollees that are enrolled in self-insured plans at establishments that offer health insurance by firm size and State: United States, 2014, http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2014/tiib2b1.pdf

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Answers to Questions for the Record
From George Slover
Senior Policy Counsel, Consumers Union
September 22, 2015 Hearing on
"Examining Consolidation in the Health Insurance Industry
And Its Impact on Consumers"
Subcommittee on Antitrust, Competition Policy and Consumer Rights
Senate Judiciary Committee

Questions from Senator Lee

1) What is your view of the necessity for the parties to merge in order to realize the benefits and efficiencies they claim will result from the transactions?

Answer: While we do not prejudge the outcome of the Justice Department's investigation, which will consider that question as part of its analysis, we are skeptical of the need for the parties to merge to realize legitimate benefits that would reach consumers. These giant insurers are well beyond the size in which new pro-consumer economies of scale are achieved. The fact that parallel operations of the two companies can be combined into one operation is true of virtually any merger, even a merger to monopoly. The fact that merging expedites the "entry" of each merging company into the other's markets comes at the expense of the increased competition and consumer choice that would result if the two companies entered those markets without merging. Buying an entire company is not the only way to obtain experience and expertise – these can be hired.

2) How do consumers view "affordability" and "quality" when shopping for health insurance? What do consumers value when selecting a health insurance plan?

Answer: Consumers care about what they pay and what they get in return. As reflected in multiple studies, many consumers struggle to afford health coverage – affordability of coverage is a top-of-mind concern for them. For some, being able to stay with the doctor they know is important; for others, less so. But most consumers want choices. They also want costs to be kept down, without sacrificing quality of care. They want reliable coverage, with no unwanted gaps or surprise costs. Regulation can help secure some of these benefits. But competition can help create additional incentives for insurers to provide them.

Questions from Senator Tillis

1) What can Congress do to ensure that the United States Department of Justice objectively examines these proposed mergers, free from undue influence from the Administration, and without predetermining the outcome of their analysis?

Answer: Congress has a legitimate and important role in helping illuminate the issues that are important for the Justice Department to consider. The Justice Department is uniquely situated and empowered to gather the information it needs to make a careful evaluation of how these mergers are going to affect competition and consumer choice. Any decision to challenge a merger is ultimately subject to the Department being able to meet its burden to prove in court that the merger would be likely to substantially lessen competition in violation of section 7 of the Clayton Act.

2) Much has been said of the potential ability of larger health insurers to act as a check on larger provider networks. In short, the argument goes that larger insurers can better negotiate with larger provider chains, thus creating a balance that will ultimately benefit consumers.

   Do you agree with this justification? Further, do you believe that consolidation in the health insurance market is the inevitable result of consolidation in the provider market?

   Finally, please opine as to whether the Affordable Care Act has hastened consolidation in health care markets, and if so, identify the features of the Act that are most responsible for this result.

Answer: We do not believe the solution to harm from market power is to create more market power. It is equally ill-conceived to create more insurer market power to combat provider market power as it is to create more provider market power to combat insurer market power. Consumers benefit when there is meaningful choice at all levels of the market – both with insurers and with provider networks. Antitrust enforcers need to be vigilant and aggressive in stopping mergers from creating, increasing, or entrenching market power whether among providers or insurers. There is a fundamental difference between an insurer being large enough to offer provider networks the advantages of access to a large number of consumers, and an insurer being so powerful that it can dictate take-it-or-leave-it terms to providers. The former encourages healthy competition that can benefit consumers; the latter undermines competition and can result in fewer health care choices for consumers and lower quality of care. Rather than allow both insurers and providers to amass market power, antitrust enforcers should work to promote healthy competition among insurers and providers alike.

In our view, enactment of the Affordable Care Act did not change the motivations for mergers in any fundamental way. The law encourages consideration of various kinds of integration in how health care services are provided, but that is generally different from the kind of market concentration that the antitrust laws concern themselves with.

Questions from Senator Vitter

The ACA's medical loss ratio (MLR) requirement mandates that insurers spend at least 85 percent of premium revenues for large groups on claims or "activities that improve health care quality." In doing so, the MLR shields incumbents from competition. The need for sufficient scale to comply with MLRs is an impediment to start-up insurance providers while, at the same time, mergers of existing insurers is incentivized by the requirement to minimize administrative and operating costs as a percentage of revenue.

MLRs are also likely to limit the capacity of small insurers to invest in overhead needed to expand, serving as punishment for retaining funds unused for medical expenses, which, in turn, is likely to make external funding necessary.

Caps on operating expenses can also work to the advantage of hospital run health plans, where the cap is set at 20% of revenue. On the other hand, the cap on operating expenses for for-profit health insurers is set at 15%. This variance gives an advantage to hospital run health plans, which have an easier time staying under the cap because they can shift costs between medical care and administrative overhead. For-profit health insurers, since the provision on medical care is not an option, must spread their fixed operating costs over a larger base of members in order to sustain themselves while meeting the government imposed caps. They must grow larger through mergers and acquisitions.

1) What role do the ACA's medical loss ratio requirements play in calculations and decisions of health insurers to consolidate? Does the cap on operating expenses incentivize scale over competition, driving insurance industry consolidation?

Answer: We support the MLR requirements. They have resulted in billions of dollars in savings for consumers, and in disciplining of insurer pricing, and in constructive incentives to improve health care quality. We do not believe the MLR requirements disadvantage market entry by new insurers. There are significant barriers to entry, but the MLR requirements are not one of them. We also believe insurers can achieve sufficient economies without merging to levels that harm competition. The MLR requirements do not fundamentally change the motivations for merging, and it remains as important as ever that antitrust enforcers be vigilant to prevent anticompetitive mergers.

2) Do MLRs make market competition-driving high deductible health plans harder to provide, forcing insurers to avoid markets with greater moral hazard that may also have a greater need for higher administrative costs?

Answer: We do not see the MLR requirements as creating an impediment to offering high-deductible health plans where they are otherwise an attractive option for consumers.

3) Does this lack of competition result in higher health care costs for consumers? Will it do so in the future?

Answer: Consumers benefit from having the meaningful choice that effective competition helps provide. Research is quite strong that competitive hospital and insurer markets, featuring several significant players, results in better outcomes for consumers. That's why it's important for antitrust enforcers to remain active in protecting competition in all parts of the health care marketplace.

Question from Senator Leahy

Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the reauthorization process.

- Is there any justification for leaving this permanent antitrust exemption in place in its current form?

- In your view, what would be the impact on consumers if the permanent antitrust exemption for the health insurance industry is kept in place during a period of industry consolidation?

Answer: The antitrust laws are important for protecting competition and consumer choice, which leads to incentives on businesses to create better, more affordable, and more innovative products and services. Consumers Union has for many years supported efforts to remove the exemption for the business of insurance that was enacted in 1945, originally conceived as a temporary, three-year delay in applying the antitrust laws to insurance to give the industry time to adjust. In our view, the insurance industry should not be exempt from the fundamental rules of fair play on which our free-market economy is premised.

The exemption does not apply to merger enforcement, as that is not considered part of the business of insurance. But the maintenance of the exemption means that the problems associated with high market concentration are far more difficult to address. Consumers would benefit from having the antitrust laws apply in the health insurance industry as they do elsewhere in our economy. Meanwhile, it is all the more essential that mergers that lessen competition in the insurance marketplace be stopped.

U.S. Senate Judiciary Committee
Subcommittee on Antitrust, Competition policy and Consumer Rights

Hearing on
"Examining Consolidation in the Health Insurance Industry and its Impact on Consumers"

September 22, 2015

Questions for the Record

U.S. Sen. Mike Lee (R-UT)

1. **Should your acquisition of Cigna receive clearance from the Department of Justice and be consummated, will your customers see an increase or decrease in their premiums, deductibles, and/or co-pays?**

   The health care costs that consumers ultimately experience depend on a number of variables. Premiums, deductibles, and co-pays are reflective of the expected cost of medical care, including the prices for, and anticipated quantity of, health care services consumed. We expect the transaction to lower plan administrative costs and to expand and improve our product offerings, increasing the quality and breadth of services available to consumers in the market. If we are successful, consumers will benefit through better care and increased affordability. Individuals who purchase and pay for their own insurance can expect improved value. Further, many of Anthem's and Cigna's members are in large employer plans that self-insure and contract with us to provide administrative services only (ASO), where the employer pays for the cost of care. These large employer customers will directly benefit from the efficiencies we expect to achieve through this transaction as the cost-of-care savings will be passed directly on to them, as noted by Dr. Paul Ginsburg in his testimony before the Committee referencing a recent study that examined the impact of plan consolidation on price.[1]

2. **In your testimony, you mentioned pursuing greater affordability and higher quality for your health insurance products. What do you mean by "affordability," and what do you mean by "quality?"**

   Pursuing greater affordability and higher quality is essential to our success. Affordability and quality matter to both Anthem and Cigna, but more importantly, they are of paramount importance to our customers. Simply put, as a result of this combination, we expect to reduce administrative expenses, improve clinical programs to better manage the cost of care, and enhance consumers' engagement in their own health care. All of these actions result in greater value by making the health care dollar stretch further. This will be accomplished through expanding the reach of the best programs of each company, in the form of more and superior product offerings, improved data analytics, and better collaboration with providers.

   Examples of the types of tools and strategies that each company has developed independently, which can be applied to the benefit of customers of the combined company, expanded, or further improved, include:

   - Transparency tools – Anthem believes in the importance of providing our customers with the tools they need to make better informed decisions regarding their health care choices.

[1] Trish, E.E., and B.J. Herring. How do health insurer market concentration and bargaining power with hospitals affect health insurance premiums? *Journal of Health Economics*, 42 (2015): 104-114.

These tools should help consumers weigh costs, quality, and evidence-based clinical outcomes data to make choices that best meet their health care needs. For instance, working with partners such as Castlight Health and Health Care Blue Book, Anthem provides consumers with clearer line-of-sight into price variations within the same geography and network. And, Cigna, through its myCigna cost and transparency tools, is able to provide its members with personalized cost estimates for over a thousand medical and dental procedures, in addition to real-time pricing for medications at 60,000 pharmacies across the country.

- Provider collaboration – Both companies also understand the importance of the patient-provider relationship in making outcome-based health care decisions. For Anthem, that has resulted in our Enhanced Personal Health Care program, which promotes that relationship by focusing on the quality of, and access to, services that have proven results. This program has contributed to Anthem successfully transitioning more than $50 billion of its total health care reimbursement spending away from traditional, volume-based fee-for-service to a more outcome-based reimbursement model. Meanwhile, the Cigna Collaborative Care program is a similar outcome-based initiative. These models result in better coordination with our provider partners, as we work together to align incentives to encourage smarter, collaborative decision-making to foster better clinical outcomes and an improved patient experience.

3. **In explaining why your merger with Cigna is necessary to achieve the efficiencies and consumer benefits you expect, you identified the length of time it would take to enter markets individually, as opposed to all-at-once through the acquisition, and constantly changing consumer demand as reasons for the deal. Are not these concerns significant barriers to entry for potential competitors?**

Competition in the health insurance industry remains robust. As referenced in my written testimony, the number of health insurers increased by 26 percent in 2015 with 70 new entrants offering coverage. Whether it is provider systems looking to enter the market themselves or new entrants looking to leverage a distinct core competency in meeting changing consumer demands, the playing field is open to all. Our objective in seeking to combine capabilities with Cigna is a recognition that each organization does something better than the other that will allow the combined entity to offer consumers increased access and greater choice in their health care decision-making, as quickly as demand requires. The health care sector is undergoing dramatic changes that will make the health insurance market even more competitive in the future. There are several drivers bringing about these changes, all aimed at making our country's health care system more efficient, while also expanding access to affordable, quality health care. This transformation is reshaping the competitive landscape across both commercial and government programs. Many types of insurers, including large insurers, regional insurers, Blue plans, previously Medicaid-only insurers, provider-sponsored plans, and others, now compete against each other in the various segments of the market. This expanded competition is expected to continue to grow, further ensuring that competition within the health insurance market will remain vigorous. The proposed transaction will not prevent new entry in any geography.

4. **What are the product and geographic market overlaps between your business and Cigna's, and what is your company willing to do to address them?**

As mapped out in my written testimony, the footprint shared by Anthem and Cigna, whether geographically or by market segment, is minimal and highly complementary. In the provision of small group insurance, Anthem has a presence in 14 states; Cigna does not market to this group. In the provision of individual insurance, Anthem does business in 14 states, and Cigna does business in 12 states; however, the combined company would only share a limited number of rating regions in just five states. In the international market, Cigna has partnerships in 30

countries to provide health coverage to multi-national firms with a global workforce; Anthem does not operate in this market.

In the Medicare Advantage (MA) market, Anthem does business in 20 states, primarily in New York, Ohio, and California. Cigna participates in the MA market in 15 states and the District of Columbia, primarily in Florida, Tennessee, Pennsylvania, and Texas. And within the six states where Anthem and Cigna offer MA products, the combined company would only share a small number of counties within those states. Anthem and Cigna each have a respective market share of about 3% in the MA market segment. In Medicaid, Anthem has contracts in 19 states; whereas, Cigna's footprint is limited to a number of counties in two states, limiting the shared footprint between the two organizations to just six counties in Texas.

Finally, in the large employer space, companies like Anthem and Cigna primarily provide administrative services to these companies rather than insurance, as many of these employers take on the risk of providing their workers' health care coverage by self-insuring. This is a sophisticated group, employing professional departments and utilizing expert consultants to manage and administer health benefits, which are quite often carved up by product segments, such as medical, dental, vision, pharmacy, and life and disability. In addition, large employers seldom seek out one all-inclusive health benefit package for employees scattered across the country. Rather, they contract with local insurers, third-party administrators, and regional, state, and local providers, depending on their needs. There is minimal overlap between the two organizations, and the complementary nature of the proposed transaction is one of the ways in which consumers will benefit from the combination of these two companies. We remain committed to working with the appropriate regulators to ensure that competition continues to thrive in the geographies and markets we service.

5. **As I'm sure you're aware, federal regulations and legislation have imposed a complex set of restrictions and requirements upon your business. Between actuarial value measures, community rating, age bands, guaranteed issue, and medical loss ratios, how does your business set itself apart from the competition?**

   The insurance market is highly regulated by a complex set of regulations and requirements, all of which ensure that all participants are good stewards of the trust that has been placed in them to help consumers manage their health care needs. Anthem's 75 years of experience in connecting people to the coverage that works best for them and their families has enabled the company to be forward thinking. As health care continues to adapt – keeping pace with changing consumption patterns and consumer demands, integrating innovative technologies, and operationalizing a high degree of regulatory scrutiny – it is incumbent upon all actors in this market to evolve. Anthem strives to position itself and its members to benefit from this evolution by increasing transparency for consumers and simplifying their access to care. Through its partnership with transparency vendors like Castlight Health and Health Care Blue Book, Anthem is able to arm consumers with the tools they need to make better informed decisions. Also, Anthem's Imaging Cost and Quality program, which proactively engages consumers by educating them on lower cost, high quality alternatives for certain procedures, has shown that it can save $220 per test, on average. Finally, through its commitment to the provider-payer relationship, Anthem has been able to foster the transition away from traditional, volume-based fee-for-service, to a more outcome-based reimbursement model, by aligning incentives to encourage smarter, collaborative decision-making to foster healthier outcomes and a better patient experience. In fact, more than $50 billion of Anthem's total health care reimbursement is now tied to these outcome-based contracts.

6. **Do you believe there is a national market for commercial health insurance plans, ASO plans, or any other product? If so, how will Anthem and Cigna's merger effect competition in those markets?**

Anthem remains steadfast in its belief that health care, in addition to being deeply personal, is inherently local. This perspective is honed through our decades of experience in the diverse communities we serve across the country. The complementary nature of this proposed transaction will result in minimal overlap, both, geographically, and by product segment, and will enable us to accelerate bringing each company's distinct expertise to bear, serving to enhance the competition that continues to thrive across the industry. Health care competition and choice is local, just as health care services are delivered locally. In many areas, local or regional plans actually drive competition and compete aggressively.

U.S. Sen. Patrick Leahy (D-VT)

Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the reauthorization process.

1. **Do you continue to support the permanent antitrust exemption for the health insurance industry? If so, what justification can you give this Committee for why it should continue to exist, and in particular, why it should exist on a permanent basis?**

   The McCarran-Ferguson statute has been interpreted to not include mergers and acquisitions of health insurers. As such, this transaction is subject to federal antitrust review by the Department of Justice, as would any other merger or acquisition. In addition, this transaction is subject to anti-trust review by 29 States' Attorneys General. The McCarran-Ferguson exemption notwithstanding, the health insurance industry is subject to a myriad of complex requirements, regulations, and oversight supervision, which Anthem works diligently to comply with at both the federal and state levels.

U.S. Sen. Dianne Feinstein (D-CA)

1. **Medical loss ratio refers to the percentage of premium dollars that go toward medical care for patients versus administrative costs. Companies that are merging often tout increased administrative efficiencies. Do you expect that increased efficiencies would translate into increased medical loss ratio percentages for Anthem in comparison to the last two years?**

   We expect the combined company to meet the statutorily imposed medical loss ratio percentages. We do expect to be able to reduce the rate of growth of the aggregate medical costs of the combined company principally as a result of our outcome-based reimbursement programs and related initiatives.

2. **What impact do you expect Anthem's merger with Cigna to have on consumers' choice of health plans?**

   Given the complementary nature of this transaction, both geographically and by market segment, consumers will continue to enjoy a high degree of choice when it comes to their health care options. In the 14 states where Anthem operates under the BlueCross or BlueCross and BlueShield brand, this transaction will provide better choices to consumers by leveraging Cigna's expertise in product lines that Anthem does not actively market, as well as by integrating the superior capabilities of both companies. In the other 36 states and Washington, DC, we believe that this combination will encourage greater competition and choice in the marketplace. Irrespective of this merger, the health insurance industry is awash with competition – whether it is provider systems applying for insurance licenses (it was estimated last year that as much as 50 percent of health systems in the U.S. had applied, or were intending to apply, for an insurance

license[2]) or new entrants to the market. This proposed deal will only serve to increase the options available to consumers in selecting the providers and plans that best fit their needs.

3. **What steps are you planning to take to ensure that it is easy for consumers to understand their exact provider network, especially if different plans offered by Anthem and Cigna have different provider networks?**

   Anthem and Cigna both make participating provider information available to our members in a number of ways – online directories, apps, by phone, and if requested, in a paper directory. We value our relationships with our provider partners and we strive to help consumers access and understand information about their health coverage. Through this transaction, we hope to bring the best practices of both companies together to improve how we engage members in their care and coverage through better data, tools, and transparency.

4. **What impact do you expect Anthem's merger with Cigna to have on the cost of premiums?**

   Premiums are determined by an array of factors. At Anthem, we work hard to provide the most affordable products that meet consumer needs. The goal of the transaction is to increase valud through improved efficiencies and applying the best capabilities of both companies as described more fully in my response above and in my testimony. This should result in improved affordability for consumers.

5. **What specific benefits to the consumer do you expect to see from Anthem's merger with Cigna?**

   The benefits to consumers from the combination of Anthem and Cigna have to do with access, affordability, and quality. Specifically, by combining the footprints of these two companies, consumers across complementary geographies and market segments will have more options, enjoying both increased choice and greater flexibility in their health care decision-making. In addition, through each company's focus on enhanced transparency and consumer-centricity, customers will have greater line-of-sight into the true costs of care, connecting them more intimately with value. Finally, both organizations' experience in designing benefits packages around quality-based clinical outcomes will enhance consumers' overall health.

6. **Are there any markets in which Anthem, Cigna, Aetna, and Humana each have more than 10% market share? If so, please identify them.**

   While market share is one factor that the Department of Justice will consider in its evaluation of the proposed transaction, we believe that it is both appropriate and necessary to consider a number of other factors to gain a full picture of insurance competition at the local level. These include, but are not limited to, geographic differences in health care prices and patterns of care, local market features, and the number and type of health plan choices available to consumers in each market segment. We believe that a comprehensive review of these and other factors will demonstrate that the two companies are complementary and well-positioned to achieve better value for our combined membership.

   What impact do you expect the proposed mergers (i.e. Anthem with Cigna and Aetna with Humana) to have on consumers' choice of health plans in the markets in which the companies each have more than 10% market share?

[2] "Medical Cost Trend: Behind the Numbers 2014," PwC.com. 2013. PricewaterhouseCoopers Health Research Institute. June 2013 <http://www.pwc.com/us/en/health-industries/behind-the-numbers/assets/medical-cost-trend-behind-the-numbers-2014.pdf>.

Consumers will benefit from new choices being made available to them. The complementary nature of the Anthem-Cigna deal, in addition to enhancing and expanding these health care options, will also enable the combined company to deliver an improved consumer experience, better quality health coverage, and greater ability to control rising medical costs, all of which will provide more value to consumers. Across Anthem's and Cigna's different geographies and market segments, if trends hold, consumers can also expect to see more competitors enter the market in the coming years.

What impact do you expect the proposed mergers (i.e. Anthem with Cigna and Aetna with Humana) to have on the cost of premiums in the markets in which the companies each have more than 10% market share?

We expect consumers will benefit from significant cost savings. Premiums are a reflection of the underlying cost of health care and the relative utilization of enrolled members. The combination of Anthem and Cigna is intended to improve value. Applying the complementary strengths of the two companies, we intend to continue to improve consumer engagement in their health care along with supporting providers' ability to better organize care delivery. Combined we will drive improved affordability.

U.S. Sen. Orrin Hatch (R-UT)

1. **The American Hospital Association has argued that the Anthem-Cigna merger would increase the Herfindahl-Hirschman Index score for commercial health insurance by over 200 points in 600 highly concentrated markets and by over 100 points in another 217 highly concentrated markets. Do you agree with those calculations? If not, why not? And if those calculations are correct, does that mean the merger will presumptively increase market power?**

   Health care is delivered locally. The Department of Justice will review this transaction by market segment on a local level. And, we are confident that the DOJ will agree with our analysis that the transaction will, in fact, result in much lower concentration ratios than the American Hospital Association have suggested.

   The American Hospital Association (AHA) calculations were not based on the economically-sound evidence considered by antitrust economists. For example, their analysis aggregated different market segments, failing to take into account the fact that, in many cases, both companies do not offer the same products to the same customers in the same geographic areas and, instead, are highly complementary. As a result, the AHA's quick look at market data is misleading when applied to the Anthem and Cigna combination. We expect the DOJ to spend the appropriate amount of time and resources – likely, months – to carefully evaluate more reliable and applicable data sets to determine the impacts to markets and market concentration.

   The calculation of market shares by MSAs, as quickly performed by the AHA, leads to an overstated picture of concentration. Two published analyses using MSAs have found that hospital providers were highly concentrated in nearly every MSA, and at HHI concentration levels much higher than the AHA has predicted would result in the insurance industry from the combination of Anthem and Cigna[3] [4].

[3] Melnick, Glenn A., et al., "The Increased Concentration of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices," *Health Affairs* Vol. 80 No. 9 (September 2011): 1728-1788.

[4] Capps, PhD, Cory, and David Dranove, PhD. "Market concentration of hospitals," Bates White Economic Consulting. June 2011. <http://www.ahipcoverage.com/wp-content/uploads/2011/06/ACOs-Cory-Capps-Hospital-Market-Consolidation-Final.pdf>.

Core Based Statistical Areas (CBSAs) used by economists more accurately depict any potential overlaps that result from combining Anthem's and Cigna's different business segments. The complementary nature of their respective business footprints means the overlaps are, in fact, quite small. In 854 of the 929 CBSAs (92 percent), either Anthem or Cigna is not present or has a negligible share of the market. A majority of the remaining CBSAs will remain below the thresholds used by the DOJ/FTC HHI guidelines used to determine whether or not a market is highly concentrated. In short, the merger will not increase concentration over levels seen today be an appreciable amount.

In virtually all areas and all customer segments and types, the combination will provide the benefits of greater efficiency while preserving choice for consumers.

U.S. Sen. Thom Tillis (R-NC)

1. **What can Congress do to ensure that the United States Department of Justice objectively examines these proposed mergers, free from undue influence from the Administration, and without predetermining the outcome of their analysis?**

   The hearing convened by this Committee – and its House counterpart – last month is an important step in this process. By inviting Anthem to present the merits of its proposed transaction, this Committee has initiated an ongoing conversation involving a wide sampling of perspectives, representing stakeholder voices from across the health care spectrum. By keeping this dialogue open, a narrative established on fact and careful analysis will continue to develop. We look forward to continued engagement with this Committee, your House of Representatives colleagues, State regulators, and the Department of Justice to ensure a thorough and comprehensive review of the proposed merger.

2. **Much has been said of the potential ability of larger health insurers to act as a check on larger provider networks. In short, the argument goes that larger insurers can better negotiate with larger provider chains, thus creating a balance that will ultimately benefit consumers.**

   - **Do you agree with this justification?**

     Anthem strives every day to deliver value to both our members and our providers. We have made a deliberate decision to collaborate closely with providers to establish programs and payment models that incentivize quality over quantity, and we actively support provider success by providing education, data, tools, and resources that enable providers to thrive in the world of outcome-based care.

     That having been established, independent research has documented the relationship between insurer and provider consolidation and negotiated prices for health care services, suggesting that market share can impact unit prices:

     - Melnick, G.A., et al. The Increased Concentration of Health Plan Markets Can Benefit Consumers through Lower Hospital Prices. *Health Affairs*, 30(9), September 2011, 1728-33.

     - Moriya, A.S., et al. Hospital Prices and Market Structure in the Hospital and Insurance Industries. *Health Economics, Policy and Law*, 5(4), October 2010, 459-79.

     - McKellar, M.R., et al. Insurer Market Structure and Variation in Commercial Health Care Spending. *Health Services Research,* 49(3), June 2014, 878-892.

- Trish, E.E., and B.J. Herring. How Do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums? *Journal of Health Economics*, 42 (2015), 104-114.

However, as plans and providers move to outcomes-based contracting, these dynamics will continue to evolve. Consumers benefit when decisions about the delivery of health care reflect both the quality and the cost of that care. Both Anthem and Cigna value the partnerships we have developed with our provider-partners and maintain that this transaction will only enhance that collaborative spirit.

- **Further, do you believe that consolidation in the health insurance market is the inevitable result of consolidation in the provider market?**

The consolidation seen in the health care industry, in general, is a result of the shared recognition that the best way to control escalating costs for consumers is through improved efficiencies resulting from the combining of like-minded entities with a shared focus on access, affordability, and quality. The efficiencies that would result from the proposed Anthem-Cigna merger would allow our complementary organizations to bring the best of what we do to more people, more quickly. It is worth noting, however, that recent independent analysis from experts at the Altarum Institute, the Robert Wood Johnson Foundation, and the Institute for Policy Research at Northwestern University has established that hospital market concentration and higher premiums go hand-in-hand.

- **Finally, please opine as to whether the Affordable Care Act has hastened consolidation in health care markets, and if so, identify the features of the Act that are most responsible for this result.**

Anthem continually seeks out ways to offer our customers affordable products that meet their needs. The health care marketplace is evolving quickly as a result of a number of factors, not the least of which are the myriad state and federal regulations that impact the cost of insurance, and rising medical costs remain a fundamental challenge to affordability for consumers. Together, Anthem and Cigna will be better able to collaborate with providers, while facilitating the transition toward a more value-based system designed to increase access and quality of care, lower costs, and improve health outcomes; all to the benefit of consumers.

U.S. Sen. David Vitter (R-LA)

Background: The ACA's medical loss ratio (MLR) requirement mandates that insurers spend at least 85 percent of premium revenues for large groups on claims or "activities that improve health care quality." In doing so, the MLR shields incumbents from competition. The need for sufficient scale to comply with MLRs is an impediment to start-up insurance providers while, at the same time, mergers of existing insurers is incentivized by the requirement to minimize administrative and operating costs as a percentage of revenue.

MLRs are also likely to limit the capacity of small insurers to invest in overhead needed to expand, serving as punishment for retaining funds unused for medical expenses, which, in turn, is likely to make external funding necessary.

Caps on operating expenses can also work to the advantage of hospital run health plans, where the cap is set at 20% of revenue. On the other hand, the cap on operating expenses for for-profit health insurers is set at 15%. This variance gives an advantage to hospital run health plans, which have an easier time staying under the cap because they can shift costs between

medical care and administrative overhead. For-profit health insurers, since the provision on medical care is not an option, must spread their fixed operating costs over a larger base of members in order to sustain themselves while meeting the government imposed caps. They must grow larger through mergers and acquisitions.

Questions:

1. **What role do the ACA's medical loss ratio requirements play in calculations and decisions of health insurers to consolidate? Does the cap on operating expenses incentivize scale over competition, driving insurance industry consolidation?**

   Anthem's proposed merger with Cigna is the result of a number of factors – including market conditions – but none more pronounced than the recognition that the complementary strengths of these two organizations would result in better access, affordability, and quality for consumers.

2. **Do MLRs make market competition-driving high deductible health plans harder to provide, forcing insurers to avoid markets with greater moral hazard that may also have a greater need for higher administrative costs?**

   The decision to enter any market, health care included, is informed by many factors. The health insurance marketplace is fundamentally local and robustly competitive, and we see it staying that way and becoming even more competitive as a result of Anthem's merger with Cigna.

3. **Does this lack of competition result in higher health care costs for consumers? Will it do so in the future?**

   There continues to be a high level of competition in the health insurance industry. This year alone saw 70 new entrants to the market, a 26 percent increase. Additionally, the vast majority of exchange-eligible consumers (86 percent) were able to choose from at least three insurers – up from 70 percent in 2014. And, nearly 60 percent of counties experienced a net gain of at least one issuer, while only 8 percent saw a net loss. It is also important to note that, in addition to new entrants and new product offerings, many provider systems are also entering the market. In fact, last year approximately 50 percent of health systems in the U.S. applied – or intended to apply – for an insurance license.

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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.

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[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.

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[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/wUpcs3.
[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.

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[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/hMhuzI.
[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]

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[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/8KImtA.

[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*, HEALTHCAREDIVE (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]

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[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 Judgement, *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 Judgement, 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

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[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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