



January 11, 2016

William J. Baer  
Assistant Attorney General  
U.S. Department of Justice Antitrust Division  
950 Pennsylvania Avenue NW  
Washington, D.C. 20530

**Re: Antitrust Review of the Aetna-Humana and Anthem-Cigna Mergers**

Dear Assistant Attorney General Baer:

The American Antitrust Institute (AAI) writes to express its views about the proposed mergers of health insurance companies Aetna and Humana and Anthem and Cigna. Both transactions are under review by the Antitrust Division of the United States Department of Justice (DOJ). The acquisitions are troubling for two important reasons. They are likely to substantially lessen competition in numerous health insurance markets in the U.S., to the detriment of consumers. And, crafting relief that would adequately protect consumer interests is inherently difficult.

The proposed Aetna-Humana and Anthem-Cigna mergers occur against the backdrop of highly concentrated markets for commercial health insurance, changing market conditions, and a difficult-to-forecast market landscape. The mergers stand to reverse the progress realized under the 2010 Affordable Care Act (ACA) in delivering the benefits of more competition to consumers. Moreover, the DOJ is tasked with evaluating two large mergers simultaneously, which will necessitate careful and difficult scenario analysis of markets and market dynamics under the assumption that either the Aetna-Humana or Anthem-Cigna deals are consummated, or that *both* deals are allowed to proceed.

The AAI has a long history of competition advocacy in healthcare. This ranges from congressional testimony, amicus briefs, white papers and letters, to commentary on competition involving virtually every segment of the healthcare supply chain, including chapters on healthcare competition in the 2008 and 2016 AAI transition reports.<sup>1</sup> In this case, our review of publicly available information strongly suggests that the extent of the competitive harm posed by the proposed mergers cannot be counterbalanced by any merger-specific, cognizable efficiencies, or be effectively remedied in a way that fully restores competition lost by the mergers.

In light of the foregoing, the AAI recommends that the DOJ “just say no” to the two deals that would fundamentally restructure the nation’s health insurance markets and create further incentives for “reactive” consolidation in the healthcare supply chain that are largely driven by the quest to gain

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<sup>1</sup> The AAI is an independent non-profit education, research, and advocacy organization. Its mission is to advance the role of competition in the economy, protect consumers, and sustain the vitality of the antitrust laws. For more information, see [www.antitrustinstitute.org](http://www.antitrustinstitute.org). Thanks to AAI Research Fellow, Kyle Virtue, for research assistance.

bargaining power. This letter highlights what the AAI considers to be the key issues raised by the proposed mergers.

## I. Overview of the Proposed Mergers

On July 24, 2015, Anthem, a Blue Cross Blue Shield insurer, agreed to acquire all outstanding shares of Cigna for an estimated \$54.2 billion.<sup>2</sup> Both Cigna and Anthem earn a majority of their commercial business in the self-insured employer submarket.<sup>3</sup> According to the companies' press release, a combined firm would serve 53 million medical members,<sup>4</sup> surpassing United Healthcare's estimated 46 million members, thus making Anthem the largest health insurance company by membership.<sup>5</sup>

American Medical Association (AMA) data indicate that the proposed merger of Anthem and Cigna would be presumed likely to enhance market power in 85 metropolitan statistical areas (MSAs), according to the standards set forth in the U.S. Department of Justice/Federal Trade Commission HORIZONTAL MERGER GUIDELINES (GUIDELINES).<sup>6</sup> An American Hospital Association (AHA) study found that the merger would be presumed likely to enhance market power in 600 MSAs and rural counties in the United States.<sup>7</sup>

On July 3, 2015, Aetna announced an agreement to purchase Humana for \$37 billion.<sup>8</sup> If the deal goes through, it would combine the third- and fourth-largest insurers by revenue.<sup>9</sup> According to Aetna, a combined Aetna-Humana would serve 33 million medical members.<sup>10</sup> AMA data indicate that the proposed merger of Aetna and Humana would be presumed likely to enhance market power under the GUIDELINES in 58 MSAs, while the AHA study found that the merger would have the same impact in 924 counties throughout the United States.<sup>11</sup>

If both acquisitions were consummated, the number of major health insurance companies in the U.S. would be reduced from five to three, with significantly more dramatic effects on local markets within each state. Such massive-scale elimination of competition raises concerns over higher post-merger premiums and loss of choice in providers for consumers, higher barriers to entry, and reduced incentives to innovate in these important markets. Extraordinarily large, merger-specific and

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<sup>2</sup> Press Release, Anthem & Cigna, Anthem Announces Definitive Agreement to Acquire Cigna Corporation (July 24, 2015), [http://betterhealthcaretogether.com/content/uploads/2015/10/Better-Healthcare-Together\\_Press-Release.pdf](http://betterhealthcaretogether.com/content/uploads/2015/10/Better-Healthcare-Together_Press-Release.pdf).

<sup>3</sup> *Effects on Competition of Proposed Health Insurance Mergers, Hearing Before the H. Comm. on the Judiciary, Subcomm. on Regulatory Reform, Commercial and Antitrust Law*, 114th Cong. 3–4 (Sept. 29, 2015) (revised testimony of Edmund F. Haislmaier, Senior Research Fellow, The Heritage Foundation).

<sup>4</sup> Anthem & Cigna Press Release, *supra* note 2.

<sup>5</sup> Ankur Banerjee & Ransdell Pierson, *Anthem to Buy Cigna, Creating Biggest U.S. Health Insurer*, REUTERS (July 24, 2015), <http://www.reuters.com/article/us-cigna-m-a-anthem-idUSKCN0PY12B20150724>.

<sup>6</sup> Am. Med. Ass'n, Health Policy Grp., *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2015 Update* (2015). The AMA analysis uses a combined (HMO, PPO, POS) market to measure concentration.

<sup>7</sup> Letter from Am. Med. Ass'n to the Honorable William Baer, Re: the Anthem-Cigna and Aetna-Humana Mergers 5 (Nov. 11, 2015) [hereinafter AMA Letter to DOJ], *available at* <http://big.assets.huffingtonpost.com/AMADOJmergers.pdf>.

<sup>8</sup> Press Release, Aetna, Aetna to Acquire Humana for \$37 Billion, Combined Entity to Drive Consumer-Focused, High-Value Health Care (July 3, 2015), <https://news.aetna.com/news-releases/aetna-to-acquire-humana-for-37-billion-combined-entity-to-drive-consumer-focused-high-value-health-care/>.

<sup>9</sup> Anna Wilde Mathews et al., *With Merger Deal, Aetna, Humana Get Ahead of the Pack*, WALL ST. J. (July 6, 2015), <http://www.wsj.com/articles/with-merger-deal-aetna-humana-get-ahead-of-the-pack-1436143581>.

<sup>10</sup> Aetna Press Release, *supra* note 8.

<sup>11</sup> *Competition in Health Insurance*, *supra* note 6; AMA Letter to DOJ, *supra* note 7, at 6.

cognizable efficiencies that would be passed through to consumers would be required to prevent the adverse competitive effects that would likely flow from the proposed mergers.<sup>12</sup>

## **II. The Troubled Competitive Landscape of U.S. Health Insurance Markets**

### **A. Reactive Consolidation to Gain Bargaining Power Imperils the Competitive Health of the Healthcare Supply Chain**

The proposed mergers perpetuate the cycle of “reactive” consolidation in our healthcare supply chain as insurers leverage up to counter the greater bargaining power of other, rapidly consolidating parts of the supply chain with which they do business. These include pharmaceutical companies, Group Purchasing Organizations, Pharmacy Benefit Managers, retail pharmacies, and hospitals and physician practices. Indeed, competition at each level has been gradually eliminated through mergers over the last 10–15 years, leaving just a few large rivals in each segment.

Consolidation motivated largely by the quest for greater bargaining power between various participants in the supply chain is a losing proposition for competition and consumers. Prices that are determined by bargaining between powerful buyers and sellers, as opposed to rivalry in competitive markets, rarely improve consumer welfare. But in addition to the risk of higher prices, lower quality, less choice, and loss of innovation that are the standard concerns in antitrust analysis, reactive consolidation raises the specter of potentially more damaging effects. The redundancy in the supply chain that is almost guaranteed through robust competition at each level is lost through reactive consolidation, leading to a more fragile supply chain that is less able to withstand exogenous shocks such as input market disruptions, shortages, or even information technology failures.

The AAI respectfully submits that the harm to competition and consumers caused by reactive consolidation in many of our critical supply chains such as healthcare and food should receive serious attention by antitrust enforcers, particularly in analyzing the long-term competitive effects of mergers that result in markets with a small number of large players, as is the case here. The Aetna-Humana and Anthem-Cigna cases present a unique opportunity to render agency opinion on this important and troubling competitive issue.

### **B. Commercial Health Insurance Markets are Highly Concentrated**

There is no dispute that the insurance industry is concentrated and has become increasingly so over the last twenty years. AMA data show that 64 percent of commercial health insurance markets are already highly concentrated.<sup>13</sup> Twenty percent of these markets have HHIs in excess of 4,000. Fifty-three percent of those markets have two insurers that account for 65 percent or more of the combined market for HMO, PPO, and POS insurance services. Other studies indicate that in 74 percent of states, the three largest insurers hold 80 percent or more of the market share in each of

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<sup>12</sup> U.S. Dep’t of Justice & Fed. Trade Comm’n, *Horizontal Merger Guidelines* § 10 (2010), available at <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf> [hereinafter *Horizontal Merger Guidelines*].

<sup>13</sup> AMA Letter to DOJ, *supra* note **Error! Bookmark not defined.****Error! Bookmark not defined.****Error! Bookmark not defined.**

the individual, small group, and large group market segments.<sup>14</sup> Nationally, the share of the largest four insurers increased from 74 to 83 percent from 2006 to 2014.<sup>15</sup>

Much of the growth in market shares and concentration can be attributed to horizontal mergers that have been consummated over the last decade.<sup>16</sup> And, as discussed further below, the result of previous merger activity in health insurance markets is that consumers of commercial health insurance are experiencing record high average family premiums (\$16,834) and out-of-pocket spending (\$800 per person).<sup>17</sup> Notably, the high and increasing cost of insurance has persisted while the annual growth in healthcare costs has been declining over the last decade.<sup>18</sup>

### **C. Economic Evidence Highlights the Harms Resulting from Past Insurance Industry Consolidation**

#### **1. Effects on Premiums**

Evidence of the effect of market concentration in commercial insurance markets indicates that insurance mergers have led to higher premiums for consumers.<sup>19</sup> While this evidence is not as robust as for hospital markets, it remains compelling. For example, there is persuasive evidence that payor concentration has resulted in higher premiums on the exchanges. A study of health insurance premiums on the federally facilitated marketplaces found that adding one additional insurer would lower premiums by 5.4 percent, while adding every available insurer would lower rates by 11.1 percent.<sup>20</sup> In the market for fully insured plans, premium increases have correlated with increased insurance market concentration, holding provider market concentration constant.<sup>21</sup>

Retrospective studies of previous health insurance mergers have confirmed that prices increased significantly following consolidation. Following the Aetna-Prudential merger, for example, there were substantial price increases in markets where the merger eliminated competition.<sup>22</sup> Moreover, premiums for plans offered by insurers other than the merging firms also increased, confirming

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<sup>14</sup> Gov't Accountability Office, *Private Health Insurance: Concentration of Enrollees Among Individual, Small Group, and Large Group Health Insurers from 2010-2013*, at 4 (2014), available at <http://www.gao.gov/assets/670/667245.pdf>.

<sup>15</sup> *Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask? Before the S. Comm. on the Judiciary*, 114 Cong. 5 (2015) (testimony of Leemore Dafny), available at <http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf>.

<sup>16</sup> See Susan Ladika, *The New Era of Mega-Plans*, Managed Care (Sept. 2015), <http://www.managedcaremag.com/archives/2015/9/new-era-mega-plans> (describing mergers of large insurers since 2011).

<sup>17</sup> Kaiser Family Found. & Health Research & Educ. Trust, *2014 Survey of Employer Health Benefits* 1–2 (2014), available at <http://kff.org/health-costs/report/2014-employer-health-benefits-survey>; Health Care Cost Institute, *Out-of-Pocket Spending Trends* (2013), at 1 (2014), available at <http://www.healthcostinstitute.org/files/IB%209%2010-28-14.pdf>.

<sup>18</sup> *The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition Before the Subcomm. on Regulatory Reform, Commercial and Antitrust Law of the H. Comm. on the Judiciary*, 114 Cong. 10 (2015) (testimony of Rick Pollack, President and CEO of the American Hospital Association).

<sup>19</sup> See generally Leemore Dafny, *Are Health Insurance Markets Competitive?*, 100 Am. Econ. Rev. 1399 (2010).

<sup>20</sup> See Leemore Dafny et al., *More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces* (NBER Working Paper No. w20140, 2014).

<sup>21</sup> Erin E. Trish & Bradley J. Herring, *How do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums?*, 42 J. Health Econ. 104 (2015).

<sup>22</sup> Leemore Dafny et al., *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, 102 Am. Econ. Rev. 1161 (2012).

predictions that the merger would facilitate the coordinated exercise of market power post-merger.<sup>23</sup> Likewise, a study of the United-Sierra Health merger revealed significant post-merger premium increases in the small group market.<sup>24</sup>

## 2. Effects on Quality and Innovation

In accordance with the GUIDELINES and past enforcement policy, antitrust analysis of mergers also requires a careful evaluation of potential adverse effects on quality. Although difficult to measure, the few studies evaluating quality outcomes in concentrated health care insurance markets and the larger number examining provider markets suggest that higher concentration is linked to lower quality.<sup>25</sup> For example, with regard to the hospital market, studies find that increased competition resulted in lower mortality rates.<sup>26</sup> Other studies suggest that health insurance markets require a threshold number of participants in order to assure that insurers are creating high quality products.<sup>27</sup>

A related concern is the effect of consolidation on innovation. Executives of the merging companies themselves emphasize that health reform has prompted extensive innovation as providers around the country are integrating their modes of providing care and payors are increasingly adopting payment arrangements that reward quality and create incentives for providers to control costs.<sup>28</sup> Excessive concentration created by the proposed mergers is likely to reduce incentives for engaging in risky innovation.

## III. Key Issues in the Antitrust Analysis of the Aetna-Humana and Anthem-Cigna Mergers

Given the high levels of concentration that the proposed mergers would engender (collectively and individually), and the economic evidence confirming the higher prices and other anticompetitive effects from past insurance mergers, the merging parties have a heavy burden to demonstrate why the mergers should not be blocked. In sections IV, V, and VI we consider—and refute—some of the arguments the parties are likely to make. In this section we address some key issues that further militate against permitting the mergers.

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<sup>23</sup> *Id.* at 1179–80, 1176.

<sup>24</sup> Jose Guardado et al., *The Price Effects of a Large Merger of Health Insurers: A Case Study of United-Sierra*, 1 Health Mgmt., Pol’y & Innovation 16 (2013), available at <http://www.hmpi.org/pdf/HMPI%20-%20Guardado,%20Emmons,%20Kane,%20Price%20Effects%20of%20a%20Larger%20Merger%20of%20Health%20Insurers.pdf>.

<sup>25</sup> Steven Sheingold et al., U.S. Dept. of Health and Human Servs., *Competition and Choice in the Health Insurance Marketplaces, 2014-2015: Impact on Premiums* (2015), available at <http://aspe.hhs.gov/basic-report/competition-and-choice-health-insurance-marketplaces-2014-2015-impact-premiums>. See also Martin Gaynor & William Vogt, *Antitrust and Competition in Health Care Markets*, in 1b *Handbook of Health Econ.* 1405 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000); Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation* (2012).

<sup>26</sup> Gaynor & Town, *supra* note 25, at 3.

<sup>27</sup> See Steven Sheingold et al., *supra* note 25.

<sup>28</sup> See, e.g., *Examining Consolidation in the Health Insurance Industry and its Impact on Consumers Before the Subcomm. on Antitrust, Competition Pol’y and Consumer Rights of S. Comm. on the Judiciary*, 114 Cong. 3 (2015) (testimony of Mark T. Bertolini Chairman & CEO, Aetna, Inc.), available at <http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Bertolini%20Testimony.pdf>.

### **A. Commercial Health Insurance and Medicare Advantage Plans Constitute Distinct Product Markets**

The DOJ has long held that commercial insurance is a distinct relevant market for purposes of merger analysis. In *United States v. United Healthcare*, however, the agency also found that Medicare Advantage (MA) plans constitute a distinct product market.<sup>29</sup> Based on differences in the way private plans compete for inclusion in local markets and the distinct services and benefits they offer, such a finding should also be made in Aetna-Humana and Anthem-Cigna.

Private insurance companies compete to offer the most attractive MA benefits to enrollees in a region. These companies differentiate their MA plans from Medicare, and compete with one another, by offering substantially greater benefits at lower costs to enrollees as compared to traditional Medicare. These benefits include lower co-payments, caps on total yearly out-of-pocket costs, prescription drug coverage, vision coverage, and health-club memberships.

While traditional Medicare to some extent constrains the pricing power that MA providers can exert, that constraint falls short of establishing that consumers view the costs and benefits of the two programs as substitutes.<sup>30</sup> Economic evidence of consumer preferences points to the distinctiveness of MA products. For example, a study investigating beneficiary responses to the elimination of an MA plan found enrollees selected another MA plan rather than accepting the program default of enrollment under traditional Medicare.<sup>31</sup>

The willingness of consumers to bear the additional cost of searching for an alternative plan supports the conclusion that consumers value the characteristics of MA plans and are disinclined to see traditional Medicare as a substitute. And the ongoing and increasing enrollment in MA plans, despite significant cuts in benefits following reforms under the Affordable Care Act, also suggests distinct consumer preferences for the package of benefits and managed care format of MA plans.<sup>32</sup>

With over 30 percent of Medicare beneficiaries choosing to receive services from private MA plans, competition in these local markets is vitally important. At present, MA markets are highly concentrated, with some 97 percent of markets exceeding the GUIDELINES' standards for high concentration.<sup>33</sup> Both Humana and Aetna are major players in hundreds of local Medicare Advantage markets. And of an estimated 17 million Medicare beneficiaries, Humana serves 19 percent of all Medicare Advantage beneficiaries, while Aetna serves 7 percent.<sup>34</sup> Combined, these two companies would serve over a quarter of all Medicare Advantage enrollees.

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<sup>29</sup> See, e.g., Complaint at ¶¶15–18, *United States v. UnitedHealth Grp., Inc.*, No. 1:08-cv-00322-ESH (D.D.C. 2008), available at <http://www.justice.gov/file/514126/download>.

<sup>30</sup> See Robert A. Berenson et al., *Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices*, 34 Health Aff. 1289 (Aug. 2015).

<sup>31</sup> Anna D. Sinaiko & Richard Zeckhauser, *Persistent Preferences and Status Quo Bias Versus Default Power: The Choices of Terminated Medicare Advantage Clients* (Working Paper, Harvard University, 2015).

<sup>32</sup> Anna D. Sinaiko & Richard Zeckhauser, *Medicare Advantage – What Explains Its Robust Health?*, 3 Am. J. Managed Care (forthcoming), available at <http://www.hks.harvard.edu/fs/rzeckhau/Medicare%20Advantage.pdf>.

<sup>33</sup> Brian Biles et al., Commonwealth Fund, *Competition Among Medicare's Private Health Plans: Does it Really Exist?* 3 (Aug. 25, 2015), available at [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/aug/1832\\_biles\\_competition\\_medicare\\_private\\_plans\\_ib\\_v2.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/aug/1832_biles_competition_medicare_private_plans_ib_v2.pdf).

<sup>34</sup> Gretchen Jacobson et al., *Data Note: Medicare Advantage Enrollment, by Firm, 2015*, Kaiser Family Found. (July 14, 2015), <http://kff.org/medicare/issue-brief/data-note-medicare-advantage-enrollment-by-firm-2015/>.

## **B. Existing Contractual Agreements Could Exacerbate Merger-Induced Loss of Competition**

A major feature of health insurance markets is the variety of contractual agreements that impede competition. These agreements could exacerbate the anticompetitive effects of the proposed mergers. For example, Anthem is one of 36 independent companies that operate under the “Blue” trademarks of the Blue Cross and Blue Shield Association. A requirement of operating under the trademarks is that each licensee compete as a Blue plan only in a designated “service area.” Another requirement is that the Blue plans abide by the so-called “two-thirds rule.” The rule mandates that two-thirds of annual revenue from each Blue trademark holder be attributable to service offered under the Blue trademarks.

The anticompetitive aspects of the trademark agreements—which are the subject of an antitrust class action lawsuit<sup>35</sup>—have clear implications regarding actual and potential competition in the insurance sector should the Anthem-Cigna merger be permitted to go forward. The restrictions appear to prohibit Anthem-Cigna from expanding its non-Blue business and may require Cigna to pull out of certain markets or to stop competing altogether for new business.

Moreover, experience has taught that concentrated insurance markets give rise to opportunities for large insurers to exploit their market power and deny rivals the opportunity to compete on the merits. For example, DOJ has challenged most-favored-nations (MFN) agreements that create barriers to entry and raise rivals’ costs.<sup>36</sup> The agency has also objected to inclusion of “all products clauses” by insurers in contracts with providers in certain situations.<sup>37</sup>

## **C. Consolidation Could Reverse the Benefits Created by the Affordable Care Act**

Recognizing that healthcare markets were performing sub-optimally, the 2010 Affordable Care Act (ACA) contained numerous measures designed to encourage development of more efficient organizational and financing arrangements. The law puts into place important reforms to both commercial and government marketplaces designed to promote shopping and bargaining.<sup>38</sup> Overall, the exchanges have helped increase choice and lower premiums by spurring competition among insurers. Although increased plan competition has not been universal, consumers have reaped the benefit of lower premiums where competitive entry has occurred.<sup>39</sup>

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<sup>35</sup> See Letter from Joe R. Whatley, Jr., Edith M. Kallas & Henry C. Quillen to William Baer, Assistant Att’y Gen., U.S. Dept. of Justice Antitrust Division (Aug. 13, 2015) (letter from counsel for plaintiffs in *In re Blue Cross Blue Shield Antitrust Litigation*, MDL No. 2406, Master File No. 2:13-cv-20000-RDP (N.D. Ala.) regarding the Anthem-Cigna merger).

<sup>36</sup> *United States v. Blue Cross Blue Shield of Michigan*, 809 F. Supp. 2d 665 (E.D. Mich. 2011).

<sup>37</sup> See, e.g., Complaint at ¶32, *United States v. Aetna, Inc.*, No. 3-99 CV 1398-H (June 21, 1999).

<sup>38</sup> For example, the Health Insurance Marketplaces were explicitly designed to facilitate competition among insurers and improve competitive bidding among plans competing in Medicare Advantage markets. Moreover, the ACA puts in place a number of regulations that provide greater transparency and choice and reverses the seriously flawed incentives that plagued health care markets prior to 2010. It also establishes conditions conducive to entry, including standardizing insurance products and removing incentives to engage in medical underwriting. See Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 Or. L. Rev. 811, 826–32 (2011).

<sup>39</sup> For example, when Preferred One—the largest insurer on the Minnesota exchange and which had offered the lowest rates—pulled out of the exchange for 2015, the four remaining insurers sought an average 35 percent rate increase for 2016. Louise Norris, *Minnesota Health Insurance Exchange/Marketplace*, Healthinsurance.org (Nov. 24, 2015), <https://www.healthinsurance.org/minnesota-state-health-insurance-exchange/>.

Contrary to the claims of some that health reform is somehow responsible for anticompetitive consolidation, the ACA vastly improves conditions necessary for competition to take hold and flourish. But for the ACA to provide the consumer benefits that were intended, and have recently been realized, competition in the provider and insurance markets must be maintained. The ACA relies on competitive bargaining *between* payors and providers and rivalry *within* each sector to drive price and quality to levels that best serve the public.

Currently, all four merging insurers compete on the exchanges and they overlap in a number of states.<sup>40</sup> Prior to the announced mergers, the insurers appear to have been considering further expanding their footprints on the exchanges by entering markets in a number of new states. Such entry would make for a more competitive health insurance landscape.<sup>41</sup>

If the Aetna-Humana and Anthem-Cigna mergers were consummated, it would reduce the field of formidable potential entrants into exchange markets from the “Big 5” to the “Remaining 3.” The likely effects of this consolidation would be to undermine the cost containment effects of competition in exchange markets. Consolidation that would pare the insurance sector down to less than a handful of players is likely to chill the enthusiasm for venturing into a neighbor’s market or engaging in risky innovation. This is of particular concern because while some markets have benefited from enhanced competition among commercial insurers, the hoped-for expansion in competition has not been universal. Under these circumstances, the Aetna-Humana and Anthem-Cigna mergers have the real potential to undermine the effectiveness of the ACA by dampening the prospect for further de-concentration via new entry, with adverse consequences for consumers both in terms of the cost and quality of healthcare.

#### **IV. Enhanced Bargaining Power Should Be Rejected as a Rationale for the Proposed Mergers**

There is substantial evidence that a large share of health-care cost increases is caused by dominant providers charging high prices.<sup>42</sup> Some studies also show that larger insurers pay lower reimbursements to such providers.<sup>43</sup> In other words, only a large payor can effectively bargain down the prices demanded by large providers. The merging parties are likely to advance the theory that their mergers will not harm competition and consumers because they will enable payors to counter the market power of dominant “must-have” hospitals and specialty physician practices.<sup>44</sup> And, they will argue that they would pass along such savings to their customers.

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<sup>40</sup> See Nat’l Conference of State Legislatures, *Health Insurance Exchanges or Marketplaces: State Profiles and Actions*, NCSL, [http://www.ncsl.org/portals/1/documents/health/health\\_insurance\\_exchanges\\_state\\_profiles.pdf](http://www.ncsl.org/portals/1/documents/health/health_insurance_exchanges_state_profiles.pdf) (last visited Nov. 30, 2015).

<sup>41</sup> See Bruce Japsen, *With Insurer ACA Expansions In 2015, More Obamacare Choices, Competition*, *Forbes* (Aug. 3, 2014), <http://www.forbes.com/sites/brucejapsen/2014/08/03/more-obamacare-choices-competition-with-insurer-expansions-in-2015/>.

<sup>42</sup> Martin Gaynor & Robert Town, *How Has Hospital Consolidation Affected the Price and Quality Of Hospital Care?* (Robert Wood Johnson Found. Synthesis Project, Policy Brief No. 9, 2006).

<sup>43</sup> Leemore S. Dafny, The Commonwealth Fund, *Issue Brief, Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience 1* (2015), available at [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/nov/1845\\_dafny\\_impact\\_hlt\\_ins\\_industry\\_consolidation\\_ib.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/nov/1845_dafny_impact_hlt_ins_industry_consolidation_ib.pdf).

<sup>44</sup> See Victor R. Fuchs & Peter V. Lee, *A Healthy Side of Insurer Mega-Mergers*, *Wall St. J.* (Aug. 26, 2015), <http://www.wsj.com/articles/a-healthy-side-of-insurer-mega-mergers-1440628597>.



AAI suggests that the DOJ carefully scrutinize this argument. Some studies show that higher concentration in commercial health insurance markets correlates with lower prices for hospital services.<sup>45</sup> However, the central question for merger analysis is whether cost savings from greater bargaining power will translate into *lower prices* for *consumers*. To that end, economic studies show that premiums have increased even where there were some reductions in provider costs.<sup>46</sup> This supports the notion that consumers do not benefit from lower healthcare costs through enhanced bargaining power. Leemore Dafny, a leading economic expert on health insurance matters succinctly summarized the economic learning in this area: “If past is prologue, insurance consolidation will tend 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.”<sup>47</sup>

It is no surprise, therefore, that the courts have been cautious about applying a “power buyer” defense to mergers.<sup>48</sup> The FTC and DOJ have also expressed considerable skepticism about the relevance of large buyers in the GUIDELINES, speeches and articles, litigation, and in their *Dose of Competition* report.<sup>49</sup> As past cases and agency experience suggest, there are myriad variables to consider in predicting the net outcome for consumers resulting from any merger-related shifts in bargaining power. Low demand elasticities for inpatient care, dynamic downstream responses to the exercise of buyer power, and whether buyer power created by the merger is “monopsonistic” or “countervailing” in nature all enter into what is a fundamentally complex calculation.<sup>50</sup> For example, the DOJ has found that when the dominant insurer can exercise buyer power over relatively powerless providers, consumers suffer harm in quality and access to care.<sup>51</sup>

Some antitrust experts suggest that the courts and enforcement agencies altogether *ignore* buyer power as a mitigating factor in a merger of sellers, except in exceptional circumstances.<sup>52</sup> One concern is that “powerful buyers might find it more profitable to share in their suppliers’ excess profits rather than trying to get supply prices down to competitive levels.”<sup>53</sup> Whether accomplished by coercion or sharing monopoly rents, there are documented instances in which insurers and hospitals have conspired to disadvantage their rivals.<sup>54</sup> For example, the DOJ challenged Blue Cross

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<sup>45</sup> Glenn A. Melnick et al., *The Increased Concentration of Health Plan Markets Can Benefit Consumers through Lower Hospital Prices*, 30 Health Aff. 1728 (2011); Asako S. Moriya et al., *Hospital Prices and Market Structure in the Hospital and Insurance Industries*, 5 Health Econ., Pol’y & L. 459 (2010); Erin E. Trish & Bradley J. Herring, *How do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums?*, 42 J. Health Econ. 104 (2015).

<sup>46</sup> See Dafny, *supra* note 43, at 4–6.

<sup>47</sup> Testimony of Leemore S. Dafny, *supra* note 15, at 10.

<sup>48</sup> See Phillip Areeda & Herbert Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* ¶ 943b.

<sup>49</sup> U.S. Dep’t of Justice & Fed. Trade Comm’n, *Horizontal Merger Guidelines* §8 (2010). See also, e.g., Mary Lou Steptoe, *The Power-Buyer Defense in Merger Cases*, 61 Antitrust L.J. 493 (1993); Steven C. Sunshine, Deputy Assistant Att’y Gen., Antitrust Div., Remarks Before the Brookings Health Affairs Conference, Market-Based Reforms of Health Care Delivery: Where Does Antitrust Fit In? (Jan. 23, 1995); Kevin J. Arquit, Director, Bureau of Competition, Fed. Trade Comm’n, Remarks Before the American Bar Association Section on Antitrust Law Health Care Committee, Group Buying and Antitrust (Apr. 2, 1992). Dep’t of Justice & Fed. Trade Comm’n, *Improving Health Care: A Dose of Competition* 27 (July 2004), <http://www.justice.gov/sites/default/files/atr/legacy/2006/04/27/204694.pdf>.

<sup>50</sup> John B. Kirkwood, *Buyer Power and Healthcare Prices*, Wash. L. Rev. (forthcoming 2016) (manuscript at 8–9).

<sup>51</sup> See generally Competitive Impact Statement, *United States v. Aetna, Inc.*, No. 3:99CV1398-H (D.D.C. Aug. 3, 1999); Competitive Impact Statement, *United States v. UnitedHealth Grp.*, No. 1:05-CV-012436 (D.D.C. Mar. 3, 2005).

<sup>52</sup> See Phillip Areeda & Herbert Hovenkamp, *Antitrust Law: An Analysis Of Antitrust Principles And Their Application* ¶943b.

<sup>53</sup> *Id.*

<sup>54</sup> See, e.g., *West Penn Allegheny Health System Inc. v. UPMC*, 627 F.3d 85 (3d Cir. 2010); *Texas v. Memorial Hermann Healthcare Sys.*, No. 2009-04609 (Tex. D.Ct. Jan. 26, 2009); *Heartland Surgical Specialty Hospital v. Midwest Division, Inc.*, 527 F. Supp. 2d

Blue Shield of Michigan’s use of most-favored nation (“MFN”) clauses. These clauses guaranteed the dominant insurer (Blue Cross) the most favorable insurance rates while forcing providers to raise rates on all other insurers in the state. The MFNs also allowed the dominant hospital (United Regional) to force small managed care plans (but not the Blue plan) to accept contract terms that disadvantaged United’s rival.<sup>55</sup>

## **V. Claims That Entry is “Easy” Should Be Carefully Evaluated**

Executives of the merging parties have asserted that entry into commercial and MA markets is “easy” and should assuage competitive concerns. To that end, Senator Lee’s question to the executives of Aetna and Anthem at the 2015 Senate Judiciary Committee hearings is particularly relevant. After noting that both executives had represented that entry into health insurance markets was relatively easy, Senator Lee asked, “If that’s the case, why not enter into the markets that Humana and Cigna are already in . . . instead of buying those competitors?”<sup>56</sup> Both stated that expansion has been very much in the planning of the large insurers but that the proposed mergers are one way to hasten entry into other markets.<sup>57</sup>

The fact that the merger would be necessary to facilitate entry into other markets is a warning sign for antitrust review. Namely, despite economic incentives to expand, significant obstacles have rendered new entry slow and sporadic. The GUIDELINES require that entry by potential entrants be “timely, likely and sufficient” to prevent the merging parties and remaining rivals from exercising market power. The evolving case law demands a clear economic showing that new entrants will obviate competitive concerns. In the absence of such evidence, several courts have brushed aside unsupported claims of likely entry.<sup>58</sup>

### **A. There are Significant Barriers to Entry into Health Insurance Markets**

We encourage the DOJ to rigorously apply the entry standard of the GUIDELINES and evolving case law in reviewing entry claims with regard to the Aetna-Human and Anthem-Cigna insurance markets. Entry barriers in health insurance markets arise for a number of reasons. First, experience shows that smaller health insurance firms face substantial barriers to entry. The DOJ has recognized

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1257 (D. Kan. 2007). *See also*, Scott Allen & Marchella Bombardieri, *A Handshake That Made Healthcare History*, Bos. Globe (Dec. 28, 2008), [http://www.boston.com/news/specials/healthcare\\_spotlight](http://www.boston.com/news/specials/healthcare_spotlight).

<sup>55</sup> *See* Complaint, *United States v. Blue Cross Blue Shield of Michigan*, 2:10-cv-15155 (E.D. Mich. Oct. 10, 2010).

<sup>56</sup> Senate Hearing at 2:24:30, *Examining Consolidation in the Health Insurance Industry and Its Impact on Consumers Before Subcomm. on Antitrust, Competition Policy and Consumer Rights, S. Judiciary Comm.*, 114 Cong. (Sept. 22, 2015), *available at* <http://www.judiciary.senate.gov/meetings/examining-consolidation-in-the-health-insurance-industry-and-its-impact-on-consumers>.

<sup>57</sup> *Id.* at 2:25:03; *see also* *Examining Consolidation in the Health Insurance Industry and Its Impact on Consumers Before Subcomm. on Antitrust, Competition Policy and Consumer Rights, S. Judiciary Comm.*, 114 Cong. (Sept. 22, 2015) (prepared statement of Joseph Swedish, President & CEO, Anthem, Inc.).

<sup>58</sup> U.S. Dep’t of Justice & Fed. Trade Comm’n, *Horizontal Merger Guidelines* §9 (2010), *available at* <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>; *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke’s Health Sys., Ltd.*, 778 F.3d 789 (9th Cir. 2015); *see also* *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 568 (6th Cir. 2014). For critical analysis of the application of the entry defense *see* Jonathan Baker & Carl Shapiro, *Detecting and Reversing the Decline in Horizontal Merger Enforcement*, 22 Antitrust L.J. 29 (2008); Richard Schmalensee, *Ease of Entry: Has the Concept Been Applied Too Readily?*, 56 Antitrust L.J. 41 (1987).

this phenomenon in past litigated cases, pointing out that Blue Cross enjoyed durable market power in Michigan markets because “entry into the alleged markets is difficult.”<sup>59</sup>

Second, the DOJ has identified as a barrier to entry the difficulty an untested insurer faces in assembling a cost-effective provider network. For example “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.”<sup>60</sup> In essence new entrants face what some have called a “chicken-and-egg” dilemma: healthcare providers are often unwilling to extend discounts to entrants who cannot assure a volume of patients, while entrants cannot attract consumers without a robust network. These facts led the Department to conclude in previous insurance merger cases that new entrants and rivals with small market shares “face substantial cost, reputation, and distribution disadvantages that will likely make them unable to prevent [acquiring firm] from raising prices or reducing services.”<sup>61</sup> As noted by the DOJ, “access to a local network of health care providers at rates far lower [than] those that an individual could negotiate directly.”<sup>62</sup>

Finally, brand recognition may also constitute a substantial entry barrier in the commercial health insurance markets. Brand is likely to be important to intermediaries who recommend plans to their clients or employees as well as to individuals and small employers who lack the experience or information to investigate quality themselves.<sup>63</sup> Moreover, 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 the reliability that brand recognition confers.

## **B. Requirements for Entry Defense Are Not Easily Met in this Case**

DOJ’s inquiry into entry in the Aetna-Humana and Anthem-Cigna mergers is likely to account for the fact that health insurance and delivery are undergoing substantial change. For example, some large health systems such as Tenet Healthcare and Ascension Health have integrated vertically to offer health insurance products. Unlike other insurers contemplating new entry, however, health systems face a steep learning curve in entering health insurance markets. For example, they must assemble technology and expertise to deal with the actuarial, business, and regulatory aspects of offering health insurance.<sup>64</sup> Moreover, to be viable competitors, they must secure cost-effective contracts from rivals in their markets.

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<sup>59</sup> See, e.g., Complaint at 15–16, *United States v. Blue Cross Blue Shield of Mich.*, No. 10-cv-14155-DPH-MKM (E.D. Mich. Oct. 18, 2010).

<sup>60</sup> *Id.* at 16.

<sup>61</sup> 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 <http://www.justice.gov/atr/case-document/file/514116/download>; Competitive Impact Statement, *United States v. Humana Inc.*, 1:12-CV-00464 (D.C.C. Mar. 27, 2012), available at <http://www.justice.gov/atr/case-document/competitive-impact-statement-124>.

<sup>62</sup> Pl’s Memorandum in Opposition to Def’s Mot. to Dismiss the Complaint with Prejudice at 13, *United States v. Blue Cross Blue Shield of Mich.*, No. 10-cv-14155-DPH-MKM (E.D. Mich. Oct. 18, 2010).

<sup>63</sup> Sharis A. Pozen, Acting Assistant Att’y Gen., Antitrust Div., Dep’t of Justice, Competition and Health Care: A Prescription for High-Quality, Affordable Care, Remarks as Prepared for the World Annual Leadership Summit on Mergers and Acquisitions in Health Care 7 (Mar. 19, 2012); see also Letter from Am. Hosp. Ass’n to William Baer, Assistant Att’y Gen. 11 (Aug. 5, 2015).

<sup>64</sup> See Joseph Conn, *Health IT a Key Challenge for Provider-Owned Plans*, Modern Healthcare (June 27, 2015), <http://www.modernhealthcare.com/article/20150627/MAGAZINE/306279980>; see also Gunjan Khanna et al.,

Other recent developments also raise questions about the likelihood of successful entry post-merger. A large number of co-op insurance plans established under the ACA have failed or are under state supervision, despite receiving federal subsidies.<sup>65</sup> This cautions against the use of numbers of entrants into insurance markets to satisfy the well-established requirement that entry be “sufficient,” i.e., that entrants can compete on a scale sufficient to restrain any post-merger exercise of market power.

## **VI. Insurance Regulation Will Not Mitigate the Potential Adverse Effects of the Proposed Mergers**

The merging parties may argue that federal and state regulation constrains the exercise of market power in the sale of health insurance and therefore the mergers are unlikely to harm competition. The DOJ should be prepared for this defense, which vastly overstates the impact of insurance regulation and, for a variety of compelling reasons, should not receive any significant weight in the agency’s review.

Moreover, legal precedent for recognizing any mitigating effects of regulation on the potential for competitive harm (i.e., “soft preemption”) is entirely inapplicable with regard to mergers. For example, where the Supreme Court has given weight to the existence of regulation, it did so only where the “regulatory structure [is] designed to deter and remedy anticompetitive harm.”<sup>66</sup> It also made clear that no such leeway should be given where “[t]here is nothing built into the regulatory scheme which performs the antitrust function.”<sup>67</sup> Notably, those caveats, offered in the context of alleged Sherman Act violations, would seem to apply, a fortiori, in merger cases given the incipency standard of Section 7 of the Clayton Act.

### **A. Regulation Is Unlikely to Constrain the Post-Merger Exercise of Market Power**

The regulation most commonly advanced as a mitigating factor is the Medical Loss Ratio (MLR) requirements adopted under the ACA.<sup>68</sup> The MLR regulatory scheme requires that fully insured health plans spend a minimum percentage of their premiums on medical services and quality improvement initiatives. For example, large group insurers must 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.

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McKinsey on Healthcare, *Provider-Led Health Plans: The Next Frontier—or the 1990s all over Again?*, McKinsey & Co. (Jan. 2015), <http://healthcare.mckinsey.com/provider-led-health-plans-next-frontier%E2%80%94or-1990s-all-over-again>.

<sup>65</sup> See *Obamacare Co-Op Casualties Climb to 8; More to Follow*, Ins. Bus. Mag. (Oct. 19, 2015), <http://www.ibomag.com/news/obamacare-coop-casualties-climb-to-8-more-to-follow-25920.aspx>.

<sup>66</sup> *Verizon Commc'ns Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398, 412 (2004).

<sup>67</sup> *Id.* (quoting *Silver v. New York Stock Exchange*, 373 U.S. 341, 358 (1963)). See also *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321 (1963).

<sup>68</sup> See, e.g., *Examining Consolidation in the Health Insurance Industry and its Impact on Consumers Before Subcomm. on Antitrust, Competition Pol'y and Consumer Rights, S. Comm. on the Judiciary* 114 Cong. 6–7 (Sept. 22, 2015) (testimony of Mark T. Bertolini, CEO, Aetna, Inc.), available at <http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Bertolini%20Testimony.pdf>.

Any argument that the MLR limits incentives to exercise market power by limiting profit margins does not withstand close scrutiny. For example, the MLR restrictions do not perform a regulatory function comparable to utility regulation or other regulations designed to limit monopoly pricing. MLR provisions do not function as price caps and may not effectively constrain profits. By increasing costs, insurers can enjoy higher net profits under the MLR thresholds—a scenario that can certainly hold for insurers with market power. Where MLR does not constrain an insurer—for example, where the insurer has a high MLR—the insurer can increase profits without regard to the regulation.<sup>69</sup> Moreover, regulation is inherently “behavioral” in approach and thus requires monitoring and compliance. There are strong incentives to develop workarounds to the regulation, a reason why behavioral remedies are typically disfavored.<sup>70</sup>

## **B. Regulation Does Not Address Competitive Concerns in a Merger Context**

Based on the scope and structure of the MLR regulation itself, it is also clear that it does not address basic competition concerns that arise in a merger context, for a number of reasons. First, MLR does not reach a large proportion of workers receiving health insurance: it simply does not apply to enrollees in self-insured plans, which constitute at least 61 percent of non-elderly citizens with private health insurance.<sup>71</sup> MLR regulation could not therefore be expected to protect the universe of consumers that would potentially be affected by the proposed mergers.

Second, MLR leaves unaddressed the adverse effects of diminished competition on the quality of services provided. Consumers depend on their insurers to provide adequate networks of high-quality providers; useful information about coverage; prompt claims resolution; timely and fair mechanisms to resolve disputes; and cost-effective, high quality programs to manage their care. As the nation’s experience with regulated industries teaches, firms with market power often provide sub-optimal quality even when profits are regulated.<sup>72</sup> Finally, MLR regulation is hardly airtight. A variety of mechanisms are available by which insurers may effectively disguise or offset profits by exploiting ambiguities inherent in defining “quality improvement,” or shifting costs among the parent company’s subsidiaries or divisions.<sup>73</sup>

## **C. State Insurance Rate Review and Regulation Do Not Assuage Competitive Concerns**

State insurance rate review and rate regulation do not assuage competitive concerns about health insurance mergers. To be sure, the ACA builds on the state regulation of insurance providers that focuses on providing more transparency and regulatory review of insurance pricing and coverage terms. For example, states are tasked with reviewing the reasonableness of any such price increases

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<sup>69</sup> See *Examining Consolidation in the Health Insurance Industry and its Impact on Consumers Before S. Comm. on the Judiciary, Subcomm. on Antitrust, Competition Pol’y and Consumer Rights*, 114 Cong. 14 (Sept. 22, 2015) (testimony of Leemore S. Dafny, Ph.D), available at <http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf>.

<sup>70</sup> See John E. Kwoka and Diana L. Moss, *Behavioral Merger Remedies: Evaluation and Implications for Antitrust Enforcement*, 57 *The Antitrust Bulletin* 979 (Winter 2012).

<sup>71</sup> Kaiser Family Found. and Health & Research Educ. Trust, *Employer Health Benefits: Annual Survey* 158 (2013).

<sup>72</sup> Stephen Breyer, *Regulation and its Reform* (Harvard Univ. Press, 1982).

<sup>73</sup> See Testimony of Leemore S. Dafny, *supra* note 69, at 14–15.

and must post their rate filings under review on their websites.<sup>74</sup> As of May 2014, the Department of Health and Human Services found that 43 states had “effective” review systems.<sup>75</sup>

However, federal requirements do not preempt state rate review, provide HHS with the authority to reject excessive rates, or require states to give such authority to their departments of insurance. Indeed the federal requirement applies only to the individual and small group market, excluding grandfathered plans, and requires review only of increases of 10 percent or more, hence allowing sizable increases to escape scrutiny. Moreover, most large plans escape state regulation. ERISA exempts self-funded plans from state insurance laws. As a result, 86 percent of all insurance is not covered by ACA-mandated review.<sup>76</sup>

Finally, many states require only review and their regulatory authorities lack power to deny rate increases. Moreover, those with power to reject rates do not always do so despite significant increases, and some withhold rate filing information from the public under the justification of protecting trade secrets.<sup>77</sup> In the vast majority of states, therefore, insurance regulation does not deflect the exercise of market power and is no substitute for competition.

## **VII. Divestitures on a Massive Scale Necessary to Fully Restore Competition May Be Ineffective and Impractical**

To date, the parties to the Aetna-Humana and Anthem-Cigna mergers have not proposed up-front remedies to address competitive concerns in the markets that are likely to be affected. The DOJ has settled challenges to a number of insurance industry mergers by requiring divestiture of plans in markets where the merger increased concentration beyond the GUIDELINES’ thresholds. Such remedies may be problematic in the cases of Aetna-Humana and Anthem-Cigna, for a number of reasons.

First, divestiture remedies are inherently risky given the myriad uncertainties associated with finding a viable buyer and forecasting future market conditions. An empirical “meta-analysis” of a large number of merger retrospectives demonstrates that divestitures often fail to resolve competitive problems.<sup>78</sup> Moreover, the retrospective studies of the aftermath of the UnitedHealth-Sierra and the Aetna-Prudential mergers—both of which involved consent orders requiring divestitures—reveal that the consolidations resulted in significant premium increases in numerous markets.<sup>79</sup> Indeed, the difficulties associated with crafting remedies that fully restore competition are increasingly coming to light. Problems with finding viable buyers for divested assets in the consummated Safeway-Albertsons and Hertz-Dollar Thrifty mergers, the failed Sysco-US Foods merger, and the recently challenged Staples-Office Depot merger have all raised red flags for enforcers.

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<sup>74</sup> Nat’l Conference of State Legislatures, *State Approval of Health Insurance Rate Increases*, NCSL (last updated Nov. 2014), <http://www.ncsl.org/research/health/health-insurance-rate-approval-disapproval.aspx>.

<sup>75</sup> *Id.*

<sup>76</sup> John Aloysius Cogan, *Health Insurance Rate Review*, 88 Temp. L. Rev. (forthcoming 2016), [http://papers.ssrn.com/sol3/Papers.cfm?abstract\\_id=2667214](http://papers.ssrn.com/sol3/Papers.cfm?abstract_id=2667214)

<sup>77</sup> See Dena Mendelsohn, *Health Insurance Rate-Setting: Time to Raise the Bar and Lift the Veil of Secrecy*, Health Aff. Blog (Dec. 24, 2014), <http://healthaffairs.org/blog/2014/12/24/health-insurance-rate-setting-time-to-raise-the-bar-and-lift-the-veil-of-secrecy/>.

<sup>78</sup> John Kwoka, *Mergers, Merger Control, and Remedies: A Retrospective Analysis of U.S. Policy* (2015).

<sup>79</sup> *See id.*

Second, a merger remedy must fully restore competition lost by the merger. In health insurance markets, this is a tall order. Effective divestiture remedies, for example, entail finding purchasers of assets that have the incentive and ability to adequately replace the competition lost through the merger. This requires that the merged firm guarantee that the purchaser of its assets will have, going forward, a cost-competitive network of hospitals and physicians.<sup>80</sup> In many markets, it may well be the case that the most willing and capable buyer is already a participant in the market, and divestiture to that buyer might itself worsen competitive conditions. On the other hand, de novo entrants may be less capable. And assuring that they have an adequate, cost competitive network of providers is no easy task, necessitating close review of proposed buyers and binding assurances between the buyer and network providers.

Finally, divestiture settlements require that the transition and subsequent compliance with the terms of the consent order be closely monitored. Given the potential magnitude of divestitures in the Aetna-Humana and Anthem-Cigna mergers—perhaps involving hundreds of separate markets—the task may well be beyond the feasible administrative capability of the DOJ or the judiciary.<sup>81</sup> Massive-scale divestitures under market conditions beset with uncertainties are likely to be so impractical as to render a remedy involving the proposed mergers incapable of fully restoring competition. Accordingly, given that such remedies do not address the loss of competition from the elimination of two of the largest five insurers in the nation, the DOJ should “just say no,” as it has in the past.<sup>82</sup>

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We appreciate the opportunity to share the AAI’s views on the proposed mergers of Aetna-Humana and Anthem-Cigna with the DOJ.

Sincerely,



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<sup>80</sup> See Competitive Impact Statement at 17, *United States v. Blue Cross-Blue Shield of Montana* (D. Mont. Nov. 8, 2011).

<sup>81</sup> See, e.g., *Examining Consolidation in the Health Insurance Industry and its Impact on Consumers Before S. Comm. on the Judiciary, Subcomm. on Antitrust, Competition Pol’y and Consumer Rights*, 114 Cong. 19 (Sept. 22, 2015) (testimony of Rick Pollack, CEO, Am. Health Ass’n), available at <http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Pollack%20Testimony.pdf>.

<sup>82</sup> See David A. Balto, *Health Insurance Merger Frenzy: Why DOJ Must Just Say ‘No’*, Law360 (Aug. 17, 2015), <http://www.law360.com/articles/683500/health-insurance-merger-frenzy-why-doj-must-just-say-no>. See also Tom Zanki, *FTC Studies Effects of Divestiture Orders in Mergers*, Law360 (Aug. 19, 2015), <http://www.law360.com/articles/692989/ftc-studies-effects-of-divestiture-orders-in-mergers>.