From: Juan D Moreno Martinez [juandamoreno24@hotmail.com]
Sent: Thursday, December 03, 2015 11:32 PM
To: Aetna Hearing
Subject: Aetna-Humana Deal

The Office of Insurance Regulation
Tallahassee, FL.
Re: Aetna-Humana Acquisition

First of all, I would like to thank The Office of Insurance Regulation for allowing me to express my opinion in this very important acquisition for the citizens of my State of Florida. As you already know, health insurance is a very important part of our lives. Health Insurance is more valuable than any other industry in the world because it protects our own health, the most important asset for any human being.

When I first learned about the Aetna-Humana acquisition, I thought about the thousands of people these two companies insure in Florida and around the country. As the nation's 3rd most populous state, the amount of people who will be impacted by this change is a wake up call for the entire state. Humana already has one of the biggest market share in the state of Florida and Aetna already owns Coventry Health Care of Florida, therefore, this acquisition would make Aetna, one of the biggest insurers in the State of Florida. If this deal is allowed, millions of people's health would be protected by this company, this means, it represents one of the biggest threats to people's life in our state if this deal is not properly regulated.

The Aetna-Humana acquisition would allow Aetna to have a huge control of premium rates and claim rates across the state, this mean, they would be allow to increase health insurance rates how the want and even deny coverage to millions of people by increasing rates so high that would make health insurance unaffordable for low income citizens. Aetna promises not to increase premiums in the short term but happens in the long term, 20 years from now? This must be fully disclosed before any deal is allowed.

High premiums not only affects citizens but also affects small businesses across the state. Behemoth health insurance company United Healthcare recently threatened to stop offering healthcare plans on the Affordable Healthcare Act marketplace exchanges beginning 2017 because their multi billion dollar expectations were lowered as a result of the marketplace benefits. This would leave hundreds of thousands of people without health insurance and thousands of primary care physicians without patients across the nation. What makes you think Aetna would not make a similar threat? It is very important to remember that we are not only dealing with a large insurance company but with a very large corporation that highly protects their profits. Our state is already suffering the consequences of denying a Medicaid expansion to millions of low income citizens in my state, just imagine the consequences if they stop providing health insurance through the Healthcare Marketplace established by the Affordable Healthcare Act.

Large health insurance companies are known for negotiating good deals with large hospital and physician network providers, but what happens with the small medical centers and small private practice physicians that take care of our elderly and low income population in the rural areas of our state? A lot of times, some doctors and medical centers choose to close their business or move to another state because the rates paid by the large insurance companies are so low that is hard to remain competitive in the industry. By allowing the creation of an even larger insurance company, I believe it would be very hard to compete against Aetna, therefore, it would leave less opportunity for innovation and competitive premiums. Think about it, there was

a reason why the AT&T-T-Mobile deal was not allowed, it would have been the end of a communications company that has broken the rules of price control and innovation. This can be the case for Humana. As you already know, Humana is not only a private insurance company, it also protect a large population of Medicare and Medicaid recipients; with so many changes in the industry and rising costs, this could be a very high risk deal for millions of people.

In my opinion, this is a deal that must be closely watched during the following months because it will affect millions of lives today and in the future. Aetna must fully disclose all details of this acquisition by showing how it would benefit the lives of millions of people across my State of Florida and how they are going to guarantee very low affordable premiums for everyone.

I appreciate your concern about this matter.

Sincerely,

Juan D. Moreno

From: Conahan, Linda [LConahan@gunster.com]
Sent: Thursday, December 03, 2015 9:38 AM
To: Aetna Hearing
Subject: Aetna-Humana purchase

We need more competition in the health insurance arena—not less. Aetna is a terrible carrier as experienced by me and my family personally and others in my office since we switched to their coverage.

Please do not approve the purchase.

Linda Conahan

From: ramartin1959 . [ramartin1959@gmail.com]
Sent: Sunday, December 06, 2015 1:53 PM
To: Aetna Hearing
Subject: Aetna-Humana - Oppose the merge

In the past, Aetna has explained many cost saving and efficiencies in merging or purchasing other carriers.

I pause to question where are those savings realized? These moves are benefiting shareholders, but little can be said of the end user seeing any reduced premium or expanded benefit for premium dollars paid. Premiums continue to rise, and jobs are distributed to overseas vendors.

The combined insurers will effectively reduce choices available to consumers.

I would like to know exactly where there are savings to be realized by the consumer.

I would like to understand how this is going to benefit the larger consumer market in the state by limiting the insurance providers.

Are they going to participate in the ACA market?

I believe I can anticipate the answers to these concerns, but I do hope that there are individuals involved in these discussions who consider both the immediate and very long-term impact on the market and the consumers.

Finally, I hope all involved keep in mind famed words "too big to fail"

Thank you for your consideration.

Sincerely,
Roberta Martin
[redacted]
Jacksonville, Florida

From: Toula Wootan [TWOOTAN@communityhospice.com]
Sent: Wednesday, December 16, 2015 4:07 PM
To: Aetna Hearing
Cc: Venice Gandionco
Subject: Letter Request from our Corporate office.

Dear Kevin McCarty, (Florida Office of Insurance Regulation)

It has been my pleasure to work alongside Humana since 2012, when I first met Tabitha Carlyle and was introduced the Medicare products that Humana has. Humana has been an integral part of making the Caregiver Coalition of Northeast Florida events reach the caregivers of frail seniors in our area. Each year, through the combined Caregiver Expo, and the many caregiver conferences we host, we reach approximately 1500 caregivers of a senior in our area. Many of them are seniors themselves, and have opted for the Medicare product that you have. It has been wonderful to see the agents from Humana at each of our events.

The Caregiver Coalition of Northeast Florida is the only caregiver coalition in the state of Florida. We have received local, state and national recognition for the work we have done to improve the quality of life for caregivers. The coalition works hard to reach the caregivers in our area to "become the caregiver's caregiver." We know that caregivers often die before the loved one they are caring for; many times due to neglect of their own health. Our goal is to change that, to improve the quality of life for caregivers, to offer them resources to help them in this role, and to keep them healthy! Humana has enhanced the well-being of this demographic, especially those who are seniors themselves by offering their Medicare product that focuses on preventive care to our seniors. I am proud to have Humana be a part of the role we play in reaching those who care for our frail seniors, and the seniors themselves.

As the leader of the Caregiver Coalition, I am very appreciative of the support we have received in the past, and hope that Humana will continue to be a part of this effort keep caregivers well, and able to continue in this role. Without those who care for our frail seniors, many would not receive care. We know that they are the backbone of our long term care system in the U.S. The annual dollar amount of the care they provide is reported to be $470 Billion each year. (AARP Public Policy Institute) It is a national concern for all of us, as our "oldest old" are the fasted growing part of our society, and those who are caring for them are aging as well. (The average age of the female caregiver is now 49, as opposed to 45 in 2009)
It is our goal to increase the number of caregivers we reach each year in Northeast Florida, serving them with the many free conferences we host each year, the annual Caregiver Expo, the Caregiver Connections newsletter, the website (www.mycaregiverconnection.org) and the caregiver support line. The funds donated to the Caregiver Coalition will go towards reaching more caregivers and providing them education on how to care for themselves as well as their loved ones.

Thank you in advance,

Toula Wootan

Toula F. Wootan
Community Development Officer
904.407.6211
4266 Sunbeam Road
Jacksonville, FL, 32257

From: James Kovacs [james.kovacs@dcantitrustlaw.com]
Sent: Wednesday, December 16, 2015 4:35 PM
To: Aetna Hearing; Anthem Hearing
Cc: David Balto
Subject: Comment Regarding Insurance Mergers of Anthem-Cigna and Aetna-Humana
Attachments: Comment to the Florida Office of Insurance Regulation--Anthem-Cigna and Aetna-Humana Mergers.pdf

To whom it may concern,
Please find the attached consumer and union comment regarding the health insurance mergers of Anthem-Cigna and Aetna-Humana (Public hearings on December 7th and 8th). The comment is signed by the following groups: Consumers Union, Florida CHAIN, Florida Rural Health Association, U.S. PIRG, 1199 SEIU United Healthcare Workers East - Florida Region, Consumer Watchdog, Florida Policy Institute, and Florida PIRG.

If you have any questions about the content of this comment, please contact counsel of record:

David A. Balto
James Kovacs
The Law Offices of David A. Balto
1325 G. St.
Suite 500
Washington, DC 20005
202-577-5424
David.balto@dcantitrustlaw.com
James.kovacs@dcantitrustlaw.com

Thank you very much.

Sincerely,
David Balto & James Kovacs

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James Kovacs
Law Offices of David Balto
www.dcantitrustlaw.com
1325 G Street, NW
Suite 500
Washington, DC 20005
(202)789-5424 (Office)
(317)432-5904 (Cell)

December 16, 2015

Commissioner Kevin McCarty
Florida Office of Insurance Regulation
200 East Gaines Street
Tallahassee, FL 32399

Re: Anthem-Cigna and Aetna-Humana Public Comment

Commissioner McCarty:

The undersigned consumer groups and unions have long been concerned with the competitive landscape within the health care industry. In order to improve health care and better serve patients, there must be competition within different health care markets that offers ample choice, high quality, and transparency. Competition is the key and the driving force to ensure better care at a lower price for all.

We write to you to raise concerns over the proposed consolidation in Florida's health insurance markets. As detailed below, the proposed mergers between Anthem-Cigna and Aetna-Humana will reduce the number of health insurers within Florida and could substantially lessen competition for millions of consumers. Competition between health insurers is vital to ensuring lower premiums, improving quality of care, and promoting access and choice.

We applaud the Commissioner and the Florida Office of Insurance Regulation for holding two separate hearings, one for each merger. Under Florida Law, the Florida Office of Insurance Regulation is empowered to prevent or remedy insurance mergers where the acquisition would substantially lessen competition within the state or would tend to create a monopoly.[1] While we will not offer an opinion if the mergers of Anthem-Cigna and Aetna-Humana would violate Florida Law,[2] we write this comment to raise concerns about these two mergers and health insurance consolidation in general. As detailed throughout the comment, ensuring and increasing competition within health insurance markets is critical to improving care and lowering costs.

[1] *See* Fla. Stat. § 628.461(8).
[2] The National Association of Insurance Commissioners' Model Insurance Holding Company System Regulatory Act provides detailed analysis of the "Competitive Standard" that can be used to investigate if a health insurance merger is anticompetitive. MODEL INS. HOLDING CO. SYS. REGULATORY ACT § 440-1 (Nat'l Ass'n of Ins. Comm'rs 2015)

The below comment will discuss (1) concentration and the impact of both mergers, (2) a merger's impact on consumer costs, (3) the role of efficiencies, (4) network adequacy, (5) entry and potential competition, and (6) the usage of divestitures and other remedies.

I. Florida Market Impact of the Anthem-Cigna and Aetna-Humana Mergers

The merging insurance companies, Anthem, Cigna, Aetna, and Humana, all offer insurance products within the state of Florida. According to data they presented, the merging companies cover a number of commercial lives within the state, with Aetna having 1.3 million, Cigna 1.16 million, Humana 547,888, and Anthem 471,764.[3] As a result of these two mergers, four companies, Florida Blue, UnitedHealth, Aetna, and Anthem would control just under 90 percent of the Florida commercial market, with Aetna having 19.3 and Anthem having 17 percent market share respectively.[4] Along with increasing market share within the general commercial market, the mergers could substantially lessen competition for a number of insurance products.

According to a recent report by Health Affairs relying on data from National Association of Insurance Commissioners ("NAIC"), the mergers could diminish competition within Florida's administrative-services-only ("ASO") market.[5] The ASO market relies on predominantly large employers that assume the responsibility for their employees' health care costs, but purchase administrative services through an insurer. Post-mergers, the NAIC data shows a 47 percent increase in concentration in Florida's Commercial ASO insurance market, the second highest in the country.[6]

Within local metropolitan service areas throughout Florida, post-mergers market shares and concentration for other commercial insurance would also be quite high. Data offered by the American Medical Association shows that a combined Aetna-Humana would presumptively enhance the combined firm's market power for different commercial products in Jacksonville, Sarasota, and Tampa.[7]

Some of the most significant competitive overlap concerns occur within the Medicare Advantage space. According to the non-partisan Kaiser Family Foundation, the dominant Medicare Advantage ("MA") provider in Florida is Humana, covering 37 percent of the nearly 1.6 million Floridians enrolled in a MA plan.[8] Combining Aetna and Humana would further extend Aetna's dominant position in the market and would give the combined entity over half of all Medicare Advantage enrollees in five Florida counties: Broward, Franklin, Palm Beach, Pasco, Volusia.[9] To counter the dominant MA position post-merger, the merging companies have offered data suggesting that traditional Medicare is a substitute for MA plans.[10] However, traditional

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[3] *See* Testimony of Thomas R. McCarthy, Hearing Before the Florida Office of Insurance Regulation (Dec. 7, 2015), *available at* http://goo.gl/WuII6e.
[4] *Id.*
[5] Douglas Hervey, David Muhlestein, & Austin Bordelon, HEALTH AFFS. (Dec. 1, 2015), http://goo.gl/OT70Nl.
[6] *Id.*
[7] *Markets where an Aetna-Humana merger warrants antitrust scrutiny,* AM. MED. ASSOC. (2015).
[8] Gretchen Jacobsen, Anthony Damico, & Tricia Neuman, Data Note: Medicare Advantage Enrollment, by Firm, 2015, KAISER FAMILY FOUND. (July 14, 2015), http://goo.gl/gJ1xnz.
[9] *Id.*
[10] McCarthy, *supra* note 3 (including Traditional Medicare in Medicare enrollment data).

Medicare is not a substitute for consumers seeking access to a MA plan. As noted in two separate Department of Justice ("DOJ") actions, MA plans represent their own "relevant product market," as they offer a series of additional benefits beyond those of traditional Medicare.[11] Therefore, traditional Medicare should not be considered as an alternative when analyzing these mergers.

II. Health Insurance Merger Impact on Consumer Costs

Consumers are concerned that increased market power post-mergers of Anthem-Cigna and Aetna-Humana will lead to rising costs, i.e. higher premiums and out-of-pocket charges. For Floridians, health insurance premiums continue to rise. According to data from the Florida Office of Insurance Regulation, even after rate review conducted by the Office, 2016 premiums within the individual commercial markets will be 9.5 percent higher than in 2015.[12]

There is little dispute that there is a direct correlation between insurance concentration and higher premiums.[13] Mergers between dominant insurers can make matters far worse. 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."[14] Two separate, retrospective economic studies on health insurance mergers found significant premium increases for consumers post-merger.[15] There is also economic evidence that a dominant insurer can increase rates 75 percent higher than smaller insurers within the same state.[16] The insurance mergers could also impact out-of-pocket prices as patients see increases in deductibles or other insurance related costs.[17]

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[11] Competitive Impact Statement, *United States v. UnitedHealth Group Inc. and Sierra Health Servs. Inc.*, 1:08-CV-00322 (D.D.C. Feb. 25, 2008) ("Due in large part to the lower out-of-pocket costs and richer benefits that many Medicare Advantage plans offer seniors traditional Medicare, seniors in Las Vegas area would not likely switch away from Medicare Advantage plans to traditional Medicare"); *see also* Competitive Impact Statement, *United States v. Humana Inc. and Arcadian Mang. Servs., Inc.*, No. 1:12-cv-00464 (D.D.C. March 27, 2012) (when finding MA plans as their own relevant product market noted that MA plans "offer substantially richer benefits at lower costs to enrollees than traditional Medicare does").

[12] Press Release, Florida Office of Insurance Regulation, Office Announces 2016 PPACA Individual Market Health Insurance Plan Rates to Increase 9.5% on Average (Aug. 26, 2015), *available at* http://goo.gl/BoS0XG (Aetna received a 13.9 percent increase for HMO and 15.5 percent for PPO, Cigna received a 13.2 percent increase, and Humana received a 2.3 percent increase).

[13] *See* Leemore Dafny, *Are Health Insurances Markets Competitive?*, 100 AM. ECON. REV. 1399 (2010).

[14] 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.

[15] *See* Leemore Dafny *et al.*, *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, 102 AM. ECON. REV. 1161 (2012) (finding that post-Aetna-Prudential merger, in 139 separate markets, premiums rose by roughly seven percent); *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) (finding a 13.7 increase in premiums post-merger of UnitedHealth and Sierra).

[16] 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.

[17] *See generally* Leemore Dafny, Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience, COMMONWEALTH FUND (Nov. 20, 2015), http://goo.gl/xRYb5x; *see also* Korin Miller, 6 Ways the Big Health Insurance Mergers Will Affect Your Coverage, YAHOO HEALTH (July 24, 2015), https://goo.gl/qLioCy (noting that "out-of-pocket payments could increase" because insurance coverage could limit certain services or number of visits forcing patients to pay more).

In contrast, there are no economic studies or evidence indicating that insurance mergers lead to lower prices for consumers. However, that has not prevented the merging companies from suggesting that merger will create cost savings which will be passed along to consumers.[18] Much of these supposed savings are attributed to the new merged firm's expected greater buying power, also known as monopsony power. According to proponents of the mergers, a dominant insurer can use monopsony power to lower provider reimbursement rates and pass the savings along to consumers.[19] But, there is no evidence consumers actually recoup any of these potential savings. In fact, Professor Thomas Greaney, a leading health antitrust scholar, has noted that there is actually "little incentive [for an insurer] to pass along the savings to its policyholders."[20] More likely, the now-dominant insurer would exploit its monopsony power to benefit only itself, closing off choices, and pressuring providers to cut corners on quality of care in order to meet its demands – the opposite of what consumers need.[21]

Current market regulations will not deter an insurer from raising consumer costs. Some supporters of these mergers have argued that the medical loss ratio ("MLR") "directly limits the level of insurer profits," thus protecting consumers from price increases.[22] While MLR is an important tool that requires health insurers spend 80 to 85 percent of net premiums on medical services and quality improvements, it will not adequately protect consumers from anticompetitive harm. Along with MLR not applying to self-insured plans, and the potential for MLR to be gamed by insurers to reduce consumer welfare, "MLR does not guarantee that dominant insurers will not raise premiums and as such, it is not a substitute for the pressures toward lower costs and higher quality created by a competitive market."[23]

III. Health Insurance Mergers Efficiencies

A potential benefit of mergers is the enhancement of the new company's ability to compete, by strengthening its capacity to drive down price, improve quality, enhance services, or create new products.[24] The insurers involved in both of these mergers have argued that their merger would

[18] *See* Testimony of Anthem, Hearing Before the Florida Office of Insurance Regulation (Dec. 8, 2015), *available at* http://goo.gl/V2uqFs ("medical cost savings due to the transaction will be passed on to customers").
[19] *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.
[20] *See* Thomas Greaney, *Examining Implications of Health Insurance Mergers*, HEALTH AFFS. (July 16, 2015), http://goo.gl/ETT1DB.
[21] *See Health Insurance Industry Consolidation: Hearing before the Sen. Comm. on the Judiciary, Subcomm. on Antitrust, Competition Policy, and Consumer Rights*, 114th Cong. (Sept. 22, 2015) (testimony of George Slover, Consumers Union), *available at* http://goo.gl/ojiyge ("[b]ut 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").
[22] *E.g., Effects on Competition of Proposed Health Insurer Mergers: Hearing before Comm. on the Judiciary Subcomm. on Regulatory Reform, Commercial and Antitrust Law*, 114th Cong. (Sept. 29, 2015) (testimony of Mark T. Bertolini, Chairman & CEO of Aetna, Inc.), *available at* http://goo.gl/TokebO.
[23] *Effects on Competition of Proposed Health Insurer Mergers: Hearing Before Comm. on the Judiciary Subcomm. on Regulatory Reform, Commercial and Antitrust Law*, 114th Cong. (Sept. 29, 2015) (testimony of Jamie S. King, Professor University of California, Hastings College of Law), *available at* http://goo.gl/Gje3Ci.
[24] U.S. Dep't. of Justice Fed. Trade Comm'n, Horizontal Merger Guidelines at § 6.4 (2010), *available at* https://goo.gl/Hh3dks.

create substantial efficiencies leading to improved health care quality and lower costs.[25] The issue becomes if it is really necessary for the insurers to merge to achieve these efficiencies, and if the stated efficiencies will actually benefit consumers.[26]

One of the more highly touted efficiencies of these mergers is the supposed cost-savings associated with the mergers. According to Aetna, the merger with Humana will create $1.25 billion in "synergy opportunities" and "operating efficiencies."[27] However, while the merging insurers have offered little details about the supposed savings, the bigger question is if consumers would see any benefit themselves from these savings, if they do result, in the form of lower costs. There is no evidence or scholarly studies showing that insurance mergers lead to savings for consumers. In fact, as previously noted, scholarly evidence indicates that health insurance mergers lead to higher consumer costs, not increased consumer savings.[28]

A more abstract argument raised by the merging insurers is that the mergers will allow the merged entities to improve innovation. Innovation within health delivery models is critical. Specifically, there is a need to change health care from the current volume-based system to a patient-oriented, value-based delivery model that incentivizes insurers and providers to improve care and lower costs. But, in Florida, these mergers will create new, dominant insurance entities with little incentive to improve care. When examining these mergers, industry experts have suggested that the mergers could "undercut" the critical innovation efforts needed to improve health care.[29] Such a loss in innovation would harm consumers as insurers compete less with providers to offer new insurance products.

Furthermore, the insurers have not offered sufficient details or analysis demonstrating how innovation will improve post-mergers. In fact, reviewing their testimony and data, Professor Dafny found it speculative to argue that the mergers would enhance the insurers' ability to develop and implement new value-based payment agreements, because there is no evidence a merger is required to carry out such initiatives.[30] Moreover, at a recent conference, Dafny further noted statistical evidence shows that concentrated insurance markets often have less innovative insurance product offerings, meaning mergers between insurers will not likely lead to higher quality or more innovative insurance products.[31]

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[25] *See* Testimony of Anthem, *supra* note 18; see also Testimony of Aetna, Hearing Before Florida Office of Insurance Regulation (Dec. 7, 2015), *available at* http://goo.gl/5bjXRu.
[26] Horizontal Merger Guidelines, *supra* note 24 at § 10 (to rebut a presumption of competitive harm, efficiencies must be merger-specific, cognizable, and substantiated).
[27] Press Release, Aetna, Aetna to Acquire Humana for $37 Billion, Combined Entity to Drive Consumer-Focused, High-Value Health Care (July 3, 2015), *available at* https://goo.gl/dktKof; *see also* Testimony of Aetna, *supra* note 25 ("$1.25 billion in operating cost savings projected, to be fully realized in 2018).
[28] *See* Section II.
[29] *See* Reed Abelson, *With Merging of Insurers, Questions for Patients About Costs and Innovation*, N.Y. TIMES (July 5, 2015), http://goo.gl/NPp38y.
[30] *Health Insurance Industry Consolidation: Hearing before the Sen. Comm. on the Judiciary, Subcomm. on Antitrust, Competition Policy, and Consumer Rights*, 114th Cong. 15 (Sept. 22, 2015) (testimony of Professor Leemore Dafny, Professor Northwestern University), *available at* http://goo.gl/mhExI6.
[31] Leemore Dafny, Comments at The New Health Care Industry: Integration, Consolidation, Competition in the Wake of the Affordable Care Act (Nov. 13, 2015), *available at* https://goo.gl/GNIvVj.

IV. Network Adequacy

As part of part their presentation, the insurers in both mergers have vowed to enhance network access for consumers.[32] While we commend this goal, there is a concern that the opposite could actually occur post-mergers, with consumers being forced into narrow provider networks. In designing a health insurance provider network, there is a careful balance between cost and provider access. A narrow insurance network is designed to give consumers low-price provider options at the cost of limiting the number of providers offered. Offering the *choice* of narrow network options can be consumer-friendly to cost-sensitive individuals. But, if an insurer can *force* consumers into a narrow network of providers and *eliminate* choice, that can be harmful, leaving consumers with less access and potentially lower quality of care.

In Florida, narrow insurance networks are becoming the new norm. A recent study by the Leonard Davis Institute of Health Economics and the Robert Wood Johnson Foundation found that 79 percent of individual plans in Florida use narrow networks that only include 25 percent or fewer of all area providers.[33] In fact, for 2016, no Florida health insurer will offer a preferred provider network plan.[34] According to the Florida Office of Insurance Regulation, these "skinny networks" can drive downs costs but "lead[] to network adequacy concerns."[35] These adequacy concerns can force consumers to drive great distances to seek medical care. A survey from the American College of Emergency Physicians found that 73 percent of respondents noted that narrow networks have caused disruptions in care.[36] We are concerned that these mergers could further restrict consumer access to providers and force consumers into narrow networks. Given the merging companies' stated commitment to improving access throughout Florida, we believe this is an important issue that must be addressed by the Florida Office of Insurance Regulation when analyzing the mergers.

V. Entry by Competitors and Loss of Potential Competition

The prospect of competitive entry into a relevant market "will alleviate concerns about adverse competitive effects."[37] However, entry as a defense to a merger, particularly within health insurance markets, is viewed with skepticism.[38] In their filings, the merging companies argue that there is sufficient competition and entry for a number of insurance products including

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[32] *See* Testimony of Anthem, *supra* note 18 ("Broader network coverage – more providers in network"); *see also* Testimony of Aetna, *supra* note 25 ("Enhance network access in more geographies").
[33] Dana Polsky & Janet Weiner, *State Variation in Narrow Networks on the ACA Marketplaces*, LEONARD DAVIS INST. HEALTH ECON. (Aug. 2015), *available at* http://goo.gl/kkCWAT.
[34] Lynn Hatter, *2016 Florida Healthcare Rates Raise A Question: Where Did The PPOs Go?*, WFSU.ORG (Sept. 11, 2015), http://goo.gl/rNY0aN.
[35] *See* Presentation, *Impacting the Essential Health Benefits Process: Balancing Health Insurance Benefits and Affordability* (Sept. 18, 2015) (Rich Robleto, Dept. Comm'n of Life & Health).
[36] *See* Caitlin Bronson, *Insurance commissioners blast narrow health insurance provider networks*, INSURANCE BUS. (Nov. 11, 2015), http://goo.gl/SdqhtN.
[37] Horizontal Merger Guidelines, *supra* note 24 at § 9.
[38] Christine A. Varney, Assistant Attorney Gen., Antitrust Div., U.S. Dep't of Justice, Remarks as Prepared for American Bar Association/American Health Lawyers Association Antitrust Healthcare Conference (May 24, 2010), *available at* http://goo.gl/rzPC0G ("entry defenses in the health insurance industry will be viewed with skepticism and will almost never justify an otherwise anticompetitive merger.").

Medicare Advantage and commercial insurance, including the Health Insurance Exchange operated in Florida.[39]

Recent data suggests that competitive entry by health insurers into Florida has been limited and not improved insurance competition. According to a report by the Kaiser Family Foundation, in 2016, 66 percent of all counties in Florida will now only offer insurance products from one or two insurers on the Health Insurance Exchange, with a total average of 2.6 insurers per county throughout all of Florida.[40] The report further states that "[w]ith fewer than 3 insurers, these counties may not benefit from insurer market competition to hold down premiums or offer plans with better value."[41] And while Medicare Advantage markets have seen some entry by new plans,[42] the vast majority of Florida's MA markets remain highly concentrated.[43]

There is also a significant loss of potential competition due to these two mergers. Entry into a new health insurance market requires "a large provider network to attract customers, but they also need a large number of customers to obtain sufficient price discounts from providers to be competitive with incumbents."[44] This "Catch 22" makes it nearly impossible for new, competitive entry to occur, particularly in markets dominated by incumbent insurers.[45]

However, potential competition could come from national insurers such as Anthem, Cigna, Aetna, and Humana. These national insurers have national footprints and have sufficient economies of scale to enter new insurance markets. By merging, these insurers would be foreclosing the possibility of their own future entry into new markets and improving competition. As noted by Professor Dafny, "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."[46] Professor Greaney has further stated that the "lessons of oligopoly are pertinent here: consolidation that would pare the insurance sector down to less than a handful players is likely to chill the enthusiasm for venturing into a neighbor's market... [o]ne need look no further than the airline industry for a cautionary tale."[47]

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[39] *See* Testimony of Cigna, *supra* note 18; *see also* Testimony of Aetna, *supra* note 25.
[40] Cynthia Cox, Gary Claxton & Larry Levitt, *Analysis of Insurer Participation in 2016 Marketplaces*, KAISER FAMILY FOUNDATION (Nov. 3, 2015), http://goo.gl/QcETCd.
[41] *Id.*
[42] Gretchen Jacobsen, Anthony Damico, & Tricia Neuman, W*hat's In and What's Out? Medicare Advantage Market Entries and Exits for 2016*, KAISER FAMILY FOUNDATION (Oct. 2015), http://goo.gl/6ZhW6V (finding that 15 new plans had entered the Florida market).
[43] *See* Brian Biles, Giselle Casillas & Stuart Guterman, *Competition Among Medicare's Private Health Plans: Does It Really Exist?*, COMMONWEALTH FUND at 1 (Aug. 25, 2015), *available at* http://goo.gl/nLcrud (finding that 97 percent of all Medicare Advantage markets are highly concentrated lacking sufficient MA plan competition).
[44] U.S Dep't of Justice & Fed. Trade Comm'n, *Improving Health Care: A Dose of Competition* at 254 (2004), *available at* http://goo.gl/GzIuvL.
[45] *See* Varney, *supra* note 38.
[46] Dafny, *supra* note 30.
[47] *The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition, Comm. on the Judiciary Subcomm. on Regulatory Reform, Commercial and Antitrust Law*, 114th Cong. (Sept. 10, 2015) (testimony by Professor Thomas Greaney, Saint Louis University School of Law), *available at* http://goo.gl/bceVxi (citation omitted).

Lastly, potential entry could also be stifled by the Blue Cross Blue Shield Association "two-thirds" rule.[48] Anthem is a "Blue" mark holder in a number of states and is bound by contract to ensure that two-thirds of their annual revenue must be attributable to the Blue mark. By acquiring Cigna, the combination may prevent the newly merged firm from expanding non-Blue business and may require Cigna to pull out of markets in which another Blue insurer competes. Given that Florida Blue is the largest commercial insurer throughout the state,[49] under the two-thirds rule, it may be necessary that Anthem require Cigna to become less competitive with Florida Blue in markets where the two actively compete.[50]

VI. Divestitures and Other Remedies

In nearly every anticompetitive health insurance matter for the last two decades, the DOJ has exclusively relied on the structural remedy of divestiture.[51] Divestitures require the merging insurance company spin off a number of subscribers to an alternative insurance company to restore competition. In Florida, given the significant overlaps in both commercial insurance and MA plans, the DOJ might, if it approves the merger at all, require a number of divestitures by the merging companies.

However, the sufficiency of divestitures as a suitable remedy has come under significant scrutiny. Economic research by Professor John Kwoka finds that divestitures often fail to restore competition to the marketplace.[52] Indeed that skepticism has led the DOJ, Federal Trade Commission ("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 divestitures offered as remedies, and instead blocked the mergers. When Sysco pursued its merger anyway, the court agreed with the FTC and enjoined the merger.[53]

Within health insurance markets, there is little evidence that competition is effectively restored after divestitures. In fact, in the previously cited two retrospective studies on health insurance mergers, both matters involved divestitures of covered lives for different insurance products, but the merged companies were still able to raise premiums by significant margins.[54] Additionally,

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[48] *See* Jacqueline DiChiara, *BCBS Licensing Agreement Questioned in Anthem Acquisition*, REVCYLCEINTELLIGENCE (Aug. 26, 2015), http://goo.gl/NRHoy8.

[49] *See* McCarthy, *supra* note 3.

[50] *See* Bruce Japsen, *Why Blue Cross Hates Anthem's Cigna Deal*, FORBES (July 27, 2015 8:00AM), http://goo.gl/gp9GpK (Noting that Cigna would compete with Florida Blue and stating that "Anthem would have two years after the close of a merger with Cigna to work out licensing issues").

[51] *See* Revised Final Judgment, *United States v. Aetna Inc. and Prudential Insurance Co. of Am.*, No. 3-99-cv-1398-H (N.D. Tex. Dec. 7, 1999); *see also* Final Judgment, *United States v. UnitedHealth Group Inc. and Sierra Health Servs. Inc.*, No: 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).

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

[53] 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), *available at* https://goo.gl/XfwPsW.

[54] Dafny, *supra* note 15; Guardado, *supra* note 15.

for any divestiture in these matters to be successful, the merging companies will have to ensure the purchaser of the assets will have a cost-competitive network of hospitals and physicians requiring scrutiny and continued monitoring from the DOJ.[55] Given the lack of competition within a number of Florida markets and the dominant position of four firms throughout the state, it may be difficult to divest assets to a competitor and genuinely preserve the competitive benefits of the pre-merger market structure.

While the DOJ and Florida Attorney General may be considering divestitures, the Florida Insurance Commissioner is also empowered to develop additional remedies for a health insurance merger. These remedies can be in addition to any such remedies, including divestitures, ordered by the DOJ or Florida Attorney General. For example, in the 2008 acquisition of Sierra Health by UnitedHealth, the DOJ required divestiture of MA plans in Las Vegas,[56] but the Nevada Insurance Commissioner required additional remedies. In order for the merging companies to receive approval from the Commissioner, they had to agree that no acquisition costs would be passed along to consumers or providers, that there would be no premium increases, that there would be no scaling back of benefits, and that UnitedHealth would have to take specified actions to limit the number of uninsured within the state.[57]

Given the scale of these two mergers and the potential for anticompetitive effects, targeted remedies beyond divestitures may play a critical role in ensuring that competition within Florida's health insurance markets remains stable. Should either merger be permitted to go forward, here is a short list of remedies we suggest that the Florida Office of Insurance Regulation consider, among others, that could help limit the competitive harm:

- (1) Requiring premium stability or rate control for a number of years post-merger.
- (2) Requirements ensuring that the merged company cannot scale back plan benefits.
- (3) Improving access to providers throughout the state and within local areas.
- (4) Ensuring that the merged company continues to provide the differentiated insurance products offered previously by the two companies, within the state and local areas, for a number of years.
- (5) Prohibiting the merged company from further restricting network access, and requiring the merged company to increase plan variety and network options for consumers.
- (6) Provisions to ensure that the merged company increase access and improve care within rural and underserved health insurance markets.
- (7) Requiring that the merged company pass along any cost savings associated with the merger to consumers, in the form of lower premiums and deductibles.

We would also be happy to further discuss this important issue with you directly.

[55] *See* Greaney, *supra* note 47.
[56] Final Judgment, UnitedHealth Inc. and Sierra Health Servs., No: 1:08-cv-00322.
[57] *Healthcare Check-Up: The UnitedHealth Group Acquisition of Sierra Health Services*, NEVADA BUS. (Nov. 1, 2007), http://goo.gl/Uztt13.

Conclusion

Our organizations are troubled by the consolidation within the health industry and its impact on price, access, and quality of care. Mergers between four of the five dominant insurers could further eliminate competition within the state of Florida. While the merging companies have argued supposed benefits associated with these mergers, available scholarly evidence suggests that consumers will see limited to no benefits and instead will face higher costs, less innovation, and potentially lower quality of care.

While the DOJ may ultimately seek divestiture as a remedy in local markets throughout Florida, the record of accomplishment on divestures leaves doubts that competition would be restored. For these reasons, we strongly urge the Florida Office of Insurance Regulation to use the remainder of the merger review period to carefully analyze these mergers. We also strongly recommend the Florida Office of Insurance Regulation be ready to consider the usage of other remedies beyond divestitures, should either of these mergers be permitted to go forward.

We would be happy to address any of the points raised in this comment. Please do not hesitate to contact us with any questions.

Respectfully submitted,

Consumers Union
Florida CHAIN
Florida Rural Health Association
U.S. PIRG
1199 SEIU United Healthcare Workers East – Florida Region
Consumer Watchdog
Florida Policy Institute
Consumer Action
Florida PIRG

Counsel of record for this comment is:

David A. Balto
James Kovacs
The Law Offices of David A. Balto
1325 G. St.
Suite 500
Washington, DC 20005
202-577-5424
David.balto@dcantitrustlaw.com
James.kovacs@dcantitrustlaw.com

From: naplespatriots@comcast.net
Sent: Thursday, December 17, 2015 10:50 AM
To: Aetna Hearing
Subject: Public Comment on Aetna acquisition of Humana

Florida Office of Insurance Regulation:

I am OPPOSED to Aetna's acquisition of Humana and its affiliates--i.e. "the merger." In February 2005, I obtained a CHILD ONLY health insurance policy for my daughter with Humana Health Insurance Company of Florida. Since the insurance plan was issued prior to 2010, it was "grandfathered" into the system relative to the Obamacare requirements. I have made my premium payments faithfully monthly and had no issues; in fact, we have been quite satisfied with the plan. On November 25, 2015, the day before Thanksgiving and the start of the busy holiday season, I was notified that my daughter's policy will no longer be offered in my area and that I will need to find other insurance by February 26, 2016. I have no choice but to go find plan from the Affordable Care Act Government Marketplace since for various reasons I cannot put my daughter on my own policy. Not only will my premiums for my daughter double to $200 per month, but her deductible is an outrageously high $4,250.

Please do not approve the merger since there will be fewer consumer options in the marketplace. I am quite distraught of having to obtain new insurance that is not acceptable and not by choice. The proposed merger has already negatively impacted my life and the life of my family.

Thank you,

Melanie Doyle
Naples, FL

From: Jeff Scott [JScott@flmedical.org]
Sent: Thursday, December 17, 2015 2:19 PM
To: Aetna Hearing
Cc: Henry Allen (Henry.Allen@ama-assn.org); Winn, Steve; Jason D. Winn (jwinn@jwinnlaw.com)
Subject: AMA/FMA/FOMA Comments on Aetna/Humana Proposed Merger
Attachments: florida hearing Dec 16 15.docx

Commissioner Kevin McCarty
Florida Office of Insurance Regulation
200 East Gaines Street
Tallahassee, FL 32399

Re: Aetna/Humana Public Comment

Dear Commissioner McCarty:

Attached please find the joint comments of the American Medical Association, the Florida Medical Association, and the Florida Osteopathic Medical Association regarding the proposed Aetna/Humana merger. If you have any questions regarding these comments, or if we can be of assistance in any way, please do not hesitate to contact me.

Thank you for your consideration,

Jeff Scott

Jeff Scott
General Counsel
850.224.6496
www.flmedical.org
facebook | twitter | linkedin

STATEMENT

of the

American Medical Association,
Florida Medical Association, Inc. and the
Florida Osteopathic Medical Association

to the

Office of Insurance Regulation
Florida Department of Financial Services

RE: Aetna Application for the Proposed Acquisition of Humana

December 17, 2015

The American Medical Association (AMA), Florida Medical Association (FMA) and Florida Osteopathic Medical Association (FOMA) appreciate the opportunity to provide comments regarding Aetna, Inc. (Aetna) application for the proposed acquisition of Humana, Inc. (Humana). We believe that high insurance market concentration is an important issue of public policy because the anticompetitive effects of insurers' exercise of market power poses a substantial risk of harm to consumers. Our analysis of data related to the proposed merger reveals significant concerns with respect to the impact on consumers in terms of health care access, quality, and affordability.

We have analyzed the likely competitive effects of this proposed merger both in the sell-side market for insurance and the buy-side market for physician services. We have considered data on competition in health insurance in recent studies on the effects of health insurance mergers, and the testimony of Aetna's executives and expert, Thomas R. McCarthy PhD of NERA Economic Consulting.

We have reviewed this matter from our long-standing perspective that competition in health insurance, not consolidation, is the right prescription for health insurer markets. Competition will lower premiums, force insurers to enhance customer service, pay bills accurately and on time, and develop and implement innovative ways to improve quality while lowering costs. Competition also allows physicians to bargain for contract terms that touch all aspects of patient care.

We have concluded that this merger will likely impair access, affordability, and innovation in the sell-side market for health insurance, and on the buy side, will deprive physicians of the ability to negotiate competitive health insurer contract terms. The result will be detrimental to consumers. "If past is prologue," notes Northwestern University Professor Leemore S. Dafny, PhD "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."[1] Therefore, Aetna has not carried *its* "burden of proof" that the effect of the acquisition would *not* substantially lessen competition in the line of insurance for which the specialty insurer is licensed or certified in the state or would not tend to create a monopoly therein."[2] Accordingly, Aetna's application to acquire Humana should be denied or, in the alternative, the Office of Insurance Regulation (OIR) should continue the hearing giving interested parties a meaningful opportunity to be heard.

PROCEDURAL BACKGROUND AND REQUEST THAT HEARING REMAIN OPEN

On November 20, OIR published in the Florida Register a notice of a public hearing on Aetna's application for the proposed acquisition of Humana. Although physicians practicing in the state of Florida have substantial interests that would be affected by OIR's decision on the application, the OIR did not serve a copy of the notice on the FMA or FOMA. Moreover, the Florida Register notice was published on the Friday before Thanksgiving and the hearing date set for December 7—notification and scheduling that made it both unlikely for those affected by the decision to timely learn of the hearing and to prepare to participate. In addition, a submission of comments by December 17 has been hampered because OIR has been dilatory in producing requested application-related documents such as Aetna's competitive analysis (which the OIR still has not produced).

A report of the hearing by *Politico Florida* describes the OIR hearing as oddly lacking the participation of anyone except "Aetna and Humana executives and witnesses for the companies"—a hearing best characterized as a mere gesture inconsistent with the important public policy issues at stake. She writes:

> Both the American Medical Association and the American Hospital Association have urged federal antitrust regulators to halt the planned merger, saying it would reduce competition and limit patient's access to quality, affordable healthcare.
>
> But at the capital on Monday, no critics appeared to oppose the merger, which would impact about 2.4 million people spanning four licensed Humana insurance companies in Florida.
>
> Instead, a panel of the office of insurance regulation… heard testimony from a handful of Aetna and Humana executives and witnesses for the companies. [3]

Aetna has said that it does not expect the acquisition, if approved, to be closed any earlier than mid-2016. Accordingly, a 30-day continuation of the hearing to allow critics of the proposed merger to have timely access to documents and to testify before the hearing panel could be

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[1] See Dafny, "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?", Testimony before the Senate Committee on the Judiciary, September 22, 2015, at 10.
[2] Section 628.4615 (8) and Section 628.465 (8) (j), Florida statutes.
[3] See *No critics show up for hearing on proposed Aetna-Humana merger*, available at http://politi.co/1IQYQLq

granted at little or no inconvenience to Aetna /Humana. We respectfully request that continuance and opportunity to be heard.

LEGAL STANDARD

Florida law places the "burden of proof" upon Aetna to prove that "the effect of the acquisition" would "not substantially lessen competition" or "would not tend to create a monopoly."[4] In other words, Aetna must produce the evidence and carry *its* burden of persuasion that the merger would not substantially lessen competition. Accordingly, this statement will begin by examining the evidence presented by Aetna through its expert, Dr. McCarthy.

THE HEALTH INSURER MERGER WOULD CREATE, ENHANCE OR ENTRENCH MARKET POWER IN THE SALE OF HEALTH INSURANCE

Commercial Health Insurance

Competition is likely to be greatest when there are many sellers, none of which have any significant market share. When there are a few firms with large shares of a market, the elimination of a competitor may create opportunities for the remaining firms to engage in coordinated interaction, including express or tacit collusion or oligopolistic behavior. For this reason the 2010 Federal Trade Commission (FTC) and Department of Justice (DOJ) Horizontal Merger Guidelines ("Horizontal Merger Guidelines") and the 2015 National Association of Insurance Commissioners Model Insurance Holding Company System Regulating Act ("NAIC Competitive Standard") are directed at preventing mergers that significantly increase the concentration of firms in concentrated markets. Oddly, Dr. McCarthy's competitive effect testimony omits any discussion of market concentration and its increase.

<u>Merger Violates NAIC Competitive Standard</u>

However, health insurer commercial insurance market shares reported by Dr. McCarthy in his Table 1 reveal a Florida statewide market that is highly concentrated under the NAIC Competitive Standard that Dr. McCarthy himself, within another context, employs in his analysis. That standard looks at the "four-firm concentration ratio" (CR 4) to determine the degree of danger to competition in a particular market. Under those standards, a highly concentrated market is one in which the shares of the four largest insurers is 75% or more of the market. According to the shares presented in Dr. McCarthy's Table 1, the shares of the four largest commercial health insurers total 78.8%. In such a highly concentrated market, there is a prima facie violation of the NAIC Competitive Standard when a firm with a 10% market share merges with a firm with a 2% or more market share.

Such a prima facie violation of the NAIC Competitive Standard occurs in the case of the proposed merger because, according to Dr. McCarthy, Aetna has more than a 10% market share (13.6%, according to Dr. McCarthy) and Humana's market share is more than 2% (5.7%,

[4] Section 628.4615 (8) and Section 628.465 (8) (j), Florida Statutes.

according to Dr. McCarthy). See McCarthy Table 1. Therefore, far from describing an Aetna/Humana merger that would allow it to carry the burden of proving that the merger does *not* substantially lessen competition, Dr. McCarthy's table describes the opposite—a merger that is prima facie anticompetitive.

Moreover, Dr. McCarthy made no effort to rebut the prima facie violation of the NAIC Competitive Standard in commercial health insurance. For example, a prima facie violation of the NAIC Competitive Standard could hypothetically be rebutted by establishing ease of entry into the Florida commercial health insurance market. However, Dr. McCarthy's entire discussion of entry is directed at the market for individually underwritten plans where he concedes that the merger would give the parties a troubling market share and he engages in speculation that at some future date there will be net entry. (More on that later.) Therefore, Aetna's application to acquire Humana cannot be approved under the Florida legal standard.

Merger Violates Federal Antitrust Merger Enforcement Standards

The result is no different if we consider the competitive effect of the merger under the Horizontal Merger Guidelines. The DOJ defines relevant health insurance markets as local rather than statewide in health insurer merger cases. This position should not be controversial in this matter since Aetna witnesses testified that health insurance markets are local.[5] Utilizing data obtained from HealthLeaders-Interstudy Managed Market Surveyor from January 1, 2013, the AMA has determined the commercial health insurance market concentrations and change in market concentrations that would result from the merger in metropolitan statistical areas within the state of Florida.[6]

The AMA analysis shows the proposed Aetna acquisition of Humana would be presumed likely, under the Horizontal Merger Guidelines, to enhance market power in the Jacksonville, Florida, Metropolitan Statistical Area (MSA) where the post-merger Herfindahl-Hirschman Index (HHI) of market concentration would be 2592 (meaning "highly concentrated") and the increase in the HHI would be 289 points. Similarly, the merger would be presumed likely to enhance market power both in the Sarasota-Bradenton-Venice MSA (post-merger HHI of 2723 and an HHI increase of 260) and in the Tampa-St. Petersburg-Clearwater MSA (post-merger HHI of 2576 and an increase of 204 points). There are also additional heavily populated MSAs where under the Horizontal Merger Guidelines, the Aetna/Humana merger potentially raises significant competitive concerns. They include: Fort Lauderdale-Pompano Beach-Deerfield Beach,

[5] The local nature of health care delivery and the marketing and other business practices of health insurers strongly suggest that health insurance markets are local. Consumers buy coverage that serves them close to where they work and live. See US Senate testimony of Professor Leemore Dafny at http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf

[6] Following the example of DOJ, the AMA has measured market concentration by using the Herfindahl-Hirschman Index (HHI) instead of the CR4. The HHI is the sum of the squares of the market shares of every firm in the relevant market. Markets with HHIs less than 1500 are characterized as unconcentrated. Those with HHIs between 1500 and 2500 are moderately concentrated, and those with HHIs more than 2500 are highly concentrated. Mergers in moderately concentrated markets that change the HHI by more than 100 are deemed by the merger guidelines to potentially raise significant competitive concerns and often warrant scrutiny. Mergers in highly concentrated markets that raise the HHI more than 200 are presumed likely to enhance market power.

Lakeland-Winter Haven, Miami-Miami Beach-Kendall, and West Palm Beach-Boca Raton-Boynton Beach.

In sum, under the Horizontal Merger Guidelines, the merger would create market structures that would facilitate express or tacit collusion or oligopolistic behavior and would therefore substantially lessen competition. Because Dr. McCarthy did not address this issue, Aetna has not met its burden of proof to show that the merger would not substantially lessen competition or tend to create a monopoly in commercial health insurance within the state of Florida. Consequently, the merger must not be approved.

Florida Commercial Enrollment—Individually Underwritten Plans

While we have already established that the merger must not be approved because of its effect in the commercial insurance market, Dr. McCarthy has chosen to do an analysis of what he claims to be a market for "individually underwritten plans," and so we will here assume a market for commercial insurance plans sold to individuals.

Merger Violates NAIC Competitive Standard

In his testimony, Dr. McCarthy concedes that the Aetna/Humana 37.7% combined share of individually underwritten plans raises the specter of a merged firm that might unilaterally exercise market power. (Dr. McCarthy testified that 30% is the threshold for when a merger raises antitrust concerns.) However he continues to ignore the market concentration and oligopolistic concerns also raised by the merger. The share of the four largest insurers of individually underwritten plans exceeds the NAIC's Competitive Standard threshold of 75% (it is 83.7%) such that it too is "highly concentrated." (By comparison, the four-firm concentration ratio for domestic airlines is 62%.)[7] There is prima facie evidence of a violation of the Competitive Standard because Aetna has more than a 10% share (it is 20.3%) and Humana has more than 2% (it is 17.3%).

Merger Violates Federal Antitrust Merger Enforcement Standards

We have also analyzed the merger under the lens of the Horizontal Merger Guidelines. The post-merger HHI is more than 2500 (it is 3053), meaning that the market would become highly concentrated. Because the change in the HHI is more than 200 (it is 705), the merger under the federal guidelines is presumed likely to be anticompetitive.

The Loss of Competition Would Be Durable Regardless of the Insurance Exchange

The insurance exchange (now called the "health insurance marketplace") is no cure for reversing the lack of choice that would occur in many Florida markets if the proposed merger were approved. Insurer participation in healthcare.gov 2015-2016 has not been encouraging in

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

Florida. According to a Kaiser Family Foundation analysis of insurer participation in 2016 marketplaces, within 67 Florida counties the average number of insurers will be 2.6. [8] That is down from 3.8 in 2015, showing a substantial net exit from the market. Sixty-six percent of these 67 counties will have only one or two insurers. Even UnitedHealth Group Inc. with its brand name, provider networks, and Florida market share of 20.5% in commercial insurance is reportedly considering exiting the exchange.[9]

Given the high market share of a combined Aetna/Humana, the flunked NAIC four-firm concentration ratio standard, and the Kaiser study results for Florida documenting net exit from the marketplaces, allowing the merger of Aetna/Humana, two of the three largest competitors in individually underwritten plans, would result in a total collapse of competition. In any event, Aetna has not carried its burden of proof that the effect of the acquisition would not substantially lessen competition in the market for commercial insurance plans sold to individuals.

Medicare Advantage

The merger would combine the largest insurer of Medicare Advantage (Humana) with the fourth largest (Aetna) to form a Medicare Advantage insurer with a 44% market share, a much higher share than the 30% threshold that Dr. McCarthy in his testimony concedes is associated with antitrust concerns.[10] Most troubling, however, is that the merger would further concentrate a market that is already highly concentrated among a small number of firms.[11]

Merger Violates NAIC Competitive Standard

Under the NAIC Competitive Standard the Medicare Advantage market is highly concentrated. The total market share of the four largest firms in the market is 79%. Also there is prima facie evidence of a violation of the competitive standard because Humana has more than a 10% share (it is 37.4%) and Aetna has more than 2% (it is 6.1%).

When the Herfindahl–Hirschman Index of market concentration is used as in the Horizontal Merger Guidelines, the Aetna/Humana merger is shown to have a substantial anticompetitive impact on a staggering number of Florida counties. According to a market study employing the Horizontal Merger Guidelines and commissioned by the American Hospital Association (AHA), the merger is presumed to be anticompetitive (likely to enhance market power) in 44 Florida Medicare Advantage group plan markets (evaluated geographically as counties, following the DOJ practice which is to account for federal regulations). For individual Medicare Advantage

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[8] See *Analysis of Insurer Participation in 2016 Marketplaces.* Kaiser Family Foundation at http://kff.org/health-reform/issue-brief/analysis-of-insurer-participation-in-2016-marketplaces/.

[9] *UnitedHealth may exit Obamacare individual exchange*. Reuters. See http://www.reuters.com/article/us-unitedhealth-grp-outlook-idUSKCN0T81E020151119.

[10] For a discussion of the dismal condition of competition in Medicare Advantage *See:* B. Biles, G. Casillas, and S. Guterman, *Competition Among Medicare's Private Health Plans: Does It Really Exist?* The Commonwealth Fund, August 2015;l 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/.

[11] See McCarthy Table 6.

plans, the merger is presumptively anticompetitive in 13 counties that include over one-half million (564K) individual Medicare Advantage plan enrollees and include Broward.

Medicare Advantage Comprises a Product Market That Is Separate and Distinct from Traditional Medicare

Dr. McCarthy has argued that an insurer's share of the Medicare Advantage market is of no antitrust consequence given that consumers have the option of enrolling in traditional Medicare and therefore, in Aetna's view, traditional Medicare and Medicare Advantage plans are not separate product markets.[12] Dr. McCarthy contends that 21% of persons terminating Aetna Medicare Advantage turn to traditional Medicare. This contention however proves nothing about demand substitutability i.e., whether customers have an ability and willingness to substitute away from one product to another in response to a small but significant and non-transitory increase in the quality adjusted price of an Aetna product—the well-established way of determining whether markets are separate.[13] We do not know from Dr. McCarthy's testimony why these persons left Aetna and turned to traditional Medicare. At the extreme, the patients leaving Aetna and opting for traditional Medicare may have been forced to turn to traditional Medicare. Moreover, Dr. McCarthy does not explain why the overwhelming portion of those leaving Aetna's Medicare Advantage apparently stay with Medicare Advantage. One explanation is that traditional Medicare is not an adequate substitute for Medicare Advantage, absent extreme circumstances that may account for those who switch from Aetna to traditional Medicare.

There are many critically important differences between Medicare Advantage and traditional Medicare that explain why the proposed merger should be evaluated for its effects in the Medicare Advantage market separately. Medicare Advantage plans offer substantially richer benefits at lower costs than traditional Medicare.[14] Moreover, in Medicare Advantage plans seniors can receive a single plan covering a variety of benefits that seniors in traditional Medicare must assemble themselves. The combination of richer benefits and one stop shopping accounts for the strong preference by many seniors for Medicare Advantage plans. Accordingly, seniors are not likely to switch away from Medicare Advantage plans to traditional Medicare in sufficient numbers to make an anticompetitive price increase or reduction in quality unprofitable to a Medicare Advantage insurer.[15] The closest competition to one Medicare Advantage insurer's plan is another insurer's Medicare Advantage plan and the presence of many competing Medicare Advantage insurers is what keeps quality competitive. Consequently, the Medicare Advantage and traditional Medicare programs constitute separate and distinct product markets and the proposed mergers should be evaluated for their effects in a Medicare Advantage market.[16]

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[12] See also Bertolini, "Examining Consolidation in the Health Insurance Industry and its Impact on Consumers," Testimony before the Senate Committee on the Judiciary, September 22, 2015, at 5.
[13] See Horizontal Merger Guidelines, Section 4.
[14] See *U.S. v. UnitedHealth Group and Sierra Health Services Inc*., Civil No1:08 –cu-00322 (DDC2008); United States v. Humana, No. 12-cv-00464 (D.D.C. Mar. 27, 2012), *available at*: www.justice.gov/atr/cases/f281600/281618.pdf).
[15] See competitive impact statement, *United States v. UnitedHealth*, supra, at 4-5.
[16] See *U.S. v. UnitedHealth Group and Sierra Health Services Inc*., Civil No1:08 –cu-00322 (DDC2008) (the DOJ alleged that Medicare Advantage is a distinct market separate from the Medicare market and obtained a consent decree requiring the

Notably, the DOJ has defined a separate product market for Medicare Advantage plans.[17] The DOJ has, therefore, concluded that a small but significant increase in Medicare Advantage plan premiums or reduction in benefits was unlikely to cause a sufficient number of seniors to switch to traditional Medicare such that the price increase or reduction in benefits would be unprofitable.

BARRIERS TO ENTRY AND THE NEED TO PRESERVE POTENTIAL COMPETITION

Dr. McCarthy contends that a merged Aetna/Humana could not exercise market power in the market for individually underwritten plans because of ease of entry. However, far from carrying his burden of proof, Dr. McCarthy's claim of ease of entry is belied on the face of his own Table 4. That table shows that from 2013 to 2014, the statewide market shares, ranking of market leaders, and number of competitors in the individually underwritten plans have remained mostly unchanged, with the exception of Humana and Aetna, which increased their shares but retained the same market leadership positions.

AMA's own analysis of MSA data from its *Competition in Health Insurance* studies show that in the numerous large MSAs where the merger would be anticompetitive in commercial markets, the market shares, ranking of market leaders and number of competitors have also been durable and little changed from 2010 thru 2013, the most recent timeframe for which we have data.

Rather than present data that demonstrates ease of entry, Dr. McCarthy substitutes speculation. He claims that Centene Corporation (Centene) a health insurer with a Florida presence in Medicaid long-term care will one day soon compete successfully on the insurance marketplace. However, Centene does not even appear to have a trivial market share in McCarthy's tables describing the present day Florida market for commercial insurance. Even assuming that Centene were to enter the market, it would be sheer speculation to assume that it could come close to replacing the competition lost by the merger of the second and third largest participants in the market for plans sold to individuals. Instead, the lost competition is likely to be permanent and acquired health insurer market power would be durable because barriers to entry prevent the higher profits often associated with concentrated markets from allowing new entrants to restore competitive pricing. These barriers include the need for sufficient business to permit the spreading of risk and contending with established insurance companies that have built long-term relationships with employers and other consumers.[18] In addition, a DOJ study of entry and

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divestiture of United's Medicare Advantage business in the Las Vegas area as a precondition to obtaining merger approval); *see also* Gretchen A. Jacobson, Patricia Neuman, Anthony Damico, "At Least Half Of New Medicare Advantage Enrollees Had Switched From Traditional Medicare During 2006–11," 34 *Health Affairs* (Millwood) 48, 51 (Jan. 2015), *available at*: http://content.healthaffairs.org/content/34/1/48.full.pdf; R. Town and S. Liu (2003), "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* 34(4): 719-36; L.Dafny and D. Dranove (2008), "Do Report Cards Tell Consumers Anything They Don't Already Know?" *RAND Journal of Economics* 39.

[17] See, United States v. Humana, No. 12-cv-00464 (D.D.C. Mar. 27, 2012) (complaint ¶¶ 20-21) (*avail. at* http://www.justice.gov/atr/case-document/file/499076/download); United States v. UnitedHealth Grp. Inc. & Sierra Health Servs., Inc., No. 08-cv-00322 (D.D.C. Feb. 25, 2008) (complaint ¶¶ 15-18) (*avail. at* http://www.justice.gov/atr/case-document/file/514126/download).

[18] See Robert W. McCann, *Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field,"* Health Law Handbook (Thomson West 2007); Mark V. Pauly, *Competition in Health Insurance Markets*, 51 Law & Contemp. Probs. 237

expansion in the health insurance industry found that "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."[19]

Perhaps the greatest obstacle is the so-called chicken and egg problem of health insurer market entry: health insurer entrants need to attract customers with competitive premiums that can only be achieved by obtaining discounts from providers. However providers usually offer the best discounts to incumbent insurers with a significant business—volume discounting that reflects a reduction in transaction costs and greater budget certainty. Hence, incumbent insurers have a durable cost advantage.[20]

The presence of significant entry barriers in health insurance markets was demonstrated in the 2008 hearings before the Pennsylvania Insurance Department on the competition ramifications of the proposed merger between Highmark Inc. and Independence Blue Cross. In a report commissioned by the Pennsylvania Insurance Department, LECG Corporation, a global expert services and consulting firm (LECG) concluded that it was unlikely that any competitor would be able to step into the market after a Highmark/IBC merger:

> [B]ased on our interviews of market participants and other evidence, there are a number of barriers to entry—including the provider cost advantage enjoyed by the dominant firms in those areas and the strength of the Blue brand in those areas.... On balance, the evidence suggests that to the extent the proposed consolidation reduces competition, it is unlikely that other health insurance firms will be able to step in and replace the loss in competition.[21]

Dr. McCarthy essentially argues that the health insurance marketplaces have made successful entry easy. The facts however do not bear out that claim. Recent developments only highlight the barrier to entry problem. Twelve of the 23 nonprofit insurance cooperatives, which were intended to inject competition into health insurance markets, have failed.[22] According to the Times, many Co-ops "appear to be scrambling to have enough money to cover claims as well as enroll new customers as they enter their third year."[23] According to the *Washington Post* of October 10, nearly half of the 23 Affordable Care Act (ACA) insurance co-ops, subsidized by millions of dollars in government loans, have been told by federal regulators that their finances,

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(1988); Federal Trade Commission and U.S. Department of Justice, Improving Health Care: A Dose of Competition (July,2004); *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 Law & Contemp. Probs. 195 (1988).

[19] 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.

[20] Id. at 7.

[21] LECG Inc., "Economic Analyses of the Competitive Impacts From The Proposed Consolidation of Highmark and IBC." September 10 2008, Page 9.

[22] "Marco Rubio Quietly Undermines Affordable Care Act," the New York Times, December 10, 2015.

[23] "Tough going for Co-ops," the New York Times, September 15, 2015, available at http://www.nytimes.com/2015/09/16/business/health-cooperatives-find-the-going-tough.html?ref=health.

enrollment, or business model need to "shape up." The quick death of these co-ops illustrate that even with heavy federal subsidies, health insurance is a tough business to enter.

According to a recent *New York Times* article, the Obama administration will pay only 13% of what insurance companies were expecting to receive through "risk corridors" that were expected to help insurance companies with too many sick people and too little cash to operate in the first years under the health law.[24] As we mentioned earlier, there have been reports that UnitedHealth Group Inc. may leave the marketplaces. Moreover, only two for-profit companies that were not already health insurers, reports the *Times*, have entered the state marketplaces. One of them is Oscar, which was touted by Aetna's CEO as an example of successful entry in his testimony before the Senate Judiciary Committee. However, according to the *Times*, Oscar estimated in a regulatory filing that it lost about $27.5 million last year, roughly half of its 2014 revenue. The CEO of Oscar, one of the very few new companies to even attempt entry, described the task as "quite daunting."[25] In any event, Dr. McCarthy's speculation that a new successful entrant will emerge is not evidence and Aetna has not carried *its* burden of persuasion that the merger would not substantially lessen competition.

The Loss of Potential Competition

One of the most important implications of the barriers to entry that persist with the advent of the marketplaces is the need to preserve the potential competition that would be lost if an incumbent insurer is acquired. Thus, when the largest insurer of Medicare Advantage (Humana) is acquired by the fourth-largest (Aetna) to form the largest Medicare Advantage insurer in Florida, the highly concentrated geographic markets where Humana faces little competition are deprived of their most likely entrant, Aetna. The foreclosure of this future market role serves to lessen competition. Professor Dafny expressed concern about this loss of potential competition in her Senate testimony: "[C]onsolidation 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."[26]

Commenting on the loss of potential competition that would accompany the proposed mergers, Professor Thomas L. Greaney, who is one of the country's leading experts on antitrust in healthcare, observes:

> An important issue… is whether the proposed mergers will lessen *potential competition* that was expected under the ACA (the potential entry by large insurers into each other's markets, incidentally, was the argument advanced as to why a "public option" plan was unnecessary). At present all four of the merging companies compete on the exchanges and they overlap in a number of states. [Citation omitted]. Notably, prior to the announced mergers, these insurers appear to have been considering further expanding their footprint on

[24] Supra, note 22
[25] This $1.5 billion Startup is Making Health Insurance Suck Less, Wired, March, 20, 2015, available at http://www.wired.com/2015/04/oscar-funding/.
[26] Dafny, supra note 1, at 13.

> the exchanges by entering a number of new states. [Citation omitted]. Thus reducing the array of formidable potential entrants into exchange markets from the "Big 5" to be "Remaining 3" will undermine the cost containment effects of competition in exchange markets. The lessons of oligopoly are pertinent here: 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. One need look no further than the airline industry for a cautionary tale.[27]

THE MERGER WOULD CREATE, ENHANCE OR ENTRENCH MONOPSONY POWER IN FLORIDA MARKETS FOR THE PURCHASE OF PHYSICIAN SERVICES

Just as the merger would enhance market power on the selling side of the market, it would also enhance monopsony or buyer's power in the purchase of inputs such as physician services, eviscerating physicians' ability to contract with alternative insurers in the face of unfavorable contract terms and ultimately inefficiently reducing the quality or quantity of services that physicians are able to offer patients. As Professor Dafny explained in her recent Senate testimony on this merger: "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."[28] She further explained that the "textbook monopsony scenario…pertains when there is a large buyer and fragmented suppliers."[29] This characterizes the market in which dominant health insurers purchase the services of physicians who typically work in small practices with 10 or fewer physicians.[30]

Even in markets where the merged health insurer lacks monopoly or market power to raise premiums for patients, the insurer still may have the power to force down physician compensation levels, raising antitrust concerns. Thus, in the UnitedHealth Group Inc./PacifiCare merger, the DOJ required a divestiture based on monopsony concerns in Boulder, Colorado, even though the merged entity would not necessarily have had market power in the sale of health insurance. The reason is straightforward: the reduction in compensation would lead to diminished service and quality of care, which harms consumers even though the direct prices paid by subscribers do not increase.[31]

Moreover, the reduction in the number of health insurers would create health insurer oligopolies that, through coordinated interaction, can exercise buyer power. Indeed the setting of payment

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[27] Greaney, "The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition," Testimony before the House Committee on the Judiciary, September 22, 2015, at 10.
[28] Dafny, supra note 1, at 10.
[29] Id.
[30] Carol K. Kane, PhD., American Medical Association Policy Research Perspectives: Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership, July 2015.
[31] *See* Gregory J. Werden, *Monopsony and the Sherman Act: Consumer Welfare in a New Light*, 74 ANTITRUST L.J. 707 (2007) (explaining reasons to challenge monopsony power even where there is no immediate impact on consumers); Marius Schwartz, *Buyer Power Concerns and the Aetna-Prudential Merger*, Address before the 5th Annual Health Care Antitrust Forum at Northwestern University School of Law 4-6 (October 20, 1999) (noting that anticompetitive effects can occur even if the conduct does not adversely affect the ultimate consumers who purchase the end-product), available at: http://www.usdoj.gov/atr/public/spceches/3924.wpd.

rates paid to physicians is highly susceptible to the exercise of monopsony power through coordinated interaction by health insurance companies. The payment rates offered to large numbers of physicians by single health insurers are fairly uniform, and health insurance companies have a strong incentive to follow a price leader when it comes to payment rates.

Some have argued that physicians who are unhappy with the fees they receive from a powerful insurer could turn away from that insurer and instead treat more Medicare and Medicaid patients. However, physicians cannot increase their revenue from Medicare and Medicaid in response to a decrease in commercial health insurer payment. Enrollment in these programs is limited to special populations, and these populations only have a fixed number of patients. Physicians switching to Medicare and Medicaid plans would have to incur substantial marketing costs to pull existing Medicare and Medicaid patients from their existing physicians. Moreover, public programs underpay providers. Thus, even if a physician dropping a commercial health insurer could attract Medicare and Medicaid, this strategy would be a losing proposition, especially at a time when value-based payment models require practice investments.

THE PROPOSED MEGAMERGER IS LIKELY TO HARM CONSUMERS

We have evaluated the potential effects of the proposed megamerger on both (1) the sale of health insurance products to employers and individuals (the sell side); and (2) the purchase of health care provider (including physician) services (the buy side).[32] We have concluded that on the sell side the merger is likely to result in higher premium levels to health care consumers and/or a reduction in the quality of health insurance that can take the form of a reduction in the availability of providers, a reduction in consumer service, etc. On the buy side, the merger could enable the merged entity to lower payment rates for physicians such that there would be a reduction in the quality or quantity of the services that physicians are able to offer patients.

Likely Detrimental Effects for Consumers in the Health Insurance Marketplace

Price Increases

A growing body of peer-reviewed literature suggests that greater consolidation leads to price increases, as opposed to greater efficiency or lower health care costs.

Two studies have examined the effects of past health insurance mergers on premiums. A study of the 1999 merger between Aetna and Prudential found that the increased market concentration was associated with higher premiums.[33] Most recently, a second study examined the premium impact of the 2008 merger between UnitedHealth Group Inc. and Sierra Health Services. That merger led to a large increase in concentration in Nevada health insurance markets. The study concluded that in the wake of the merger, premiums in Nevada markets increased by almost 14%

[32] See e.g. *U.S. v. Aetna Inc.*, supra note 12, at ¶¶ 17-18; *United States v. UnitedHealth Group Inc.* No. 1:05CV02436 (D.D.C., Dec. 20, 2005) (complaint), available at www.usdoj.gov/atr/cases/f213800/213815.htm.
[33] Leemore Dafny et al, "Paying a Premium on your Premium? Consolidation in the US health insurance industry," *American Economic Review* 2012; 102: 1161-1185.

relative to a control group. These findings suggest that the merging parties exploited their resulting market power, to the detriment of consumers.[34]

Also, recent studies suggest premiums for employer sponsored fully insured plans are rising more quickly in areas where insurance market concentration is increasing.[35]

Consistent with the observation that the loss of competition accompanying health insurer mergers results in higher premiums is research finding that competition among insurers is associated with lower premiums.[36] Research suggests that on the federal health insurance marketplaces, the participation of one new large carrier (i.e. UnitedHealth Group Inc.) would have reduced premiums by 5.4%, while the inclusion of all companies in the individual insurance markets could have lowered rates by 11.1%.[37] Professor Dafny observes that there are a number of studies documenting lower insurance premiums in areas with more insurers, including on the state health insurance marketplaces, the large group market, and in Medicare Advantage.[38]

Plan Quality

The merger can be expected to adversely affect health insurance plan quality. Insurers are already creating very narrow and restricted networks that force patients to go out-of-network to access care. A merger would reduce pressures on plans to offer broader networks to compete for members and would create fewer networks that are simultaneously under no competitive pressure to respond to patients' access needs. As a result, it is even more likely that patients will find themselves in inadequate networks and be forced to access out-of-network care at some point. Similarly, it is very likely that patients will find themselves at in-network hospitals where, given their restricted network plans, many of the hospitals' physicians will not have been offered a contract by the insurer.

While the relationship between insurer consolidation and plan quality requires additional research, one study in the Medicare Advantage market found that more robust competition was associated with greater availability of prescription drug benefits.[39] As Professor Dafny observes, "the competitive mechanisms linking diminished competition to higher prices operate similarly with respect to lower quality."[40]

[34] Jose R. Guardado, David W. Emmons, and Carol K. Kane, "The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra" *Health Management, Policy and Innovation*, 2013; 1(3) 16-35.
[35] Dafny, supra note 1, at 11.
[36] Dafny et al., supra note 1, at 11.
[37] Leemore Dafny, Jonathan Gruber and Christopher Ody. "More Insurers, Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces," *American Journal of Health Economics*, 2015: 1(1)53-81.
[38] Dafny supra note 1, at 11.
[39] Dafny supra, note 1 at 11.
[40] Robert Town and Su Liu, "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* (2003): 719-736.

The Health Insurer Monopsony Power Acquired Through the Merger Would Likely Degrade the Quality and Reduce the Quantity of Physician Services

Just as the proposed merger would enable the merged firm to raise premiums or reduce levels of service, it would also be likely to be able to lower payment rates for physicians to a degree that would reduce the quality or quantity of services that they offer to patients.

The DOJ has successfully challenged two health insurer mergers (half of all cases brought against health insurer mergers) based in part on DOJ claims that the mergers would have anticompetitive effects in the purchase of physician services. These challenges occurred in the merger of Aetna and Prudential in Texas in 1999,[41] and the merger of UnitedHealth Group Inc. and Pacific Care in Tucson, Arizona and in Boulder, Colorado in 2005.[42]

In a third merger matter occurring in 2010—Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan—the health insurers abandoned their merger plans when the DOJ complained that the merger "…would have given Blue Cross Michigan the ability to control physician payment rates in a manner that could harm the quality of healthcare delivered to consumers."[43]

DOJ's monopsony challenges properly reflect the Agency's conclusions that it is a mistake to assume that a health insurer's negotiating leverage acquired through merger is a good thing for consumers. On the contrary, consumers can expect higher insurance premiums."[44] Health insurer monopsonists typically are also monopolists.[45] Facing little if any competition, they lack the incentive to pass along cost savings to consumers.

Consumers do best when there is a competitive market for purchasing physician services. This was the well-documented conclusion reached in the 2008 hearings before the Pennsylvania Insurance Department on the competition ramifications of the proposed merger between Highmark, Inc. and Independence Blue Cross. Based on an extensive record of nearly 50,000 pages of expert and other commentary,[46] the Pennsylvania Insurance Department was prepared to find the proposed merger to be anticompetitive in large part because it would have granted the merged health insurer undue leverage over physicians and other health care providers. This leverage would be "to the detriment of the insurance buying public" and would result in "weaker

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[41] *U.S. v. Aetna Inc.*, supra note 12, at ¶¶ 17-18; *see also U.S. v. Aetna, Inc.*, No. 3-99 CV 1398-H, at 5-6 (Aug. 3, 1999) (revised competitive impact statement), available at *http://www.usdoj.gov/atr/case/s/f2600/2648.pdf.*

[42] *United States v. UnitedHealth Group Inc.* No. 1:05CV02436 (D.D.C., Dec. 20, 2005) (complaint), available at: www.usdoj.gov/atr/cases/f213800/213815.htm.

[43] Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans | OPA | Department of Justice, available at: http://www.justice.gov/opa/pr/blue-cross-blue-shield-michigan-and-physicians-health-plan-mid-michigan-abandon-merger-plans.

[44] Dafny, supra note 1, at 9.

[45] Peter J. Hammer and William M. Sage, *Monopsony as an Agency and Regulatory Problem in Health Care*, 71 ANTITRUST. L.J. 949 (2004).

[46] See *http://www.ins.state.pa.us/ins/lib/ins/whats_new/Excerpts_from_PA_Insurance_Dept_Expert_Reports.pdf* for background information, including excerpts from the experts.

provider networks for consumers who depend on these networks for access to quality healthcare." [47] The Pennsylvania Insurance Department further concluded:

> Our nationally renowned economic expert, LECG, rejected the idea that using market leverage to reduce provider reimbursements below competitive levels will translate into lower premiums, calling this an "economic fallacy" and noting that the clear weight of economic opinion is that consumers do best when there is a competitive market for purchasing provider services. LECG also found this theory to be borne out by the experience in central Pennsylvania, where competition between Highmark and Capital Blue Cross has been good for providers and good for consumers.[48]

For example, compensation below competitive levels hinders physicians' ability to invest in new equipment, technology, training, staff and other practice infrastructure that could improve the access to, and quality of, patient care. Such investments are critical for enabling physicians to successfully transition into new value-based payment and delivery models. The merged insurer's exercise of monopsony power may also force physicians to spend less time with patients to meet practice expenses. The mergers may also cause even tighter provider networks, reducing patient access to physicians and effectively curtailing the quantity of their services. Finally, when one or more health insurers dominate a market, physicians can be pressured not to engage in aggressive patient advocacy, a crucial safeguard of patient care.

Such reduction in service levels and quality of care causes immediate harm to consumers. In the long run, it is imperative to consider whether monopsony power will harm consumers by driving physicians from the market. Health insurer payments that are below competitive levels may reduce patient care and access by motivating physicians to retire early or seek opportunities outside of medicine that are more rewarding, financially or otherwise. According to a 2015 study released by the Association of American Medical Colleges, the U.S. will face a shortage of between 46,000-90,000 physicians by 2025. The study, which is the first comprehensive national analysis that takes into account both demographics and recent changes to care delivery and payment methods, projects shortages in both primary and specialty care.[49] Recent projections by the Health Resources and Services Administration similarly suggest a significant shortage of primary care physicians in the United States.[50]

Moreover, according to a recent survey by Deloitte, six in 10 physicians said it was likely that many physicians would retire earlier than planned in the next one to three years, a perception that Deloitte stated is fairly uniform among all physicians, irrespective of age, gender, or medical specialty.[51] According to the Deloitte survey, 57% of physicians also said that the practice of

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[47] *See* Statement of Pennsylvania Insurance Commissioner Joel Ario on Highmark and IBC Consolidation (January 22, 2009).
[48] Id.
[49] *See* IHS Inc., The Complexities of Physician Supply and Demand: Projections from 2013 to 2025. Prepared for the Association of American Medical Colleges. Washington, DC: Association of American Medical Colleges; 2015.
[50] *See* Health Resources and Services Administration, Projecting the Supply and Demand for Primary Care Physicians through 2020 in Brief (November 2013).
[51] Deloitte 2013 Survey of U.S. Physicians: Physician perspectives about health care reform in the future of the medical profession.

medicine was in jeopardy and nearly 75% of physicians thought that the "best and the brightest" may not consider a career in medicine. Finally, most physicians surveyed believed that physicians would retire or scale back practice hours, based on how the future of medicine is changing.[52]

Monopsony Anticompetitive Effects May be Especially Felt by Consumers and Physicians in The Market for Medicare Advantage

Because this merger would result in monopsony power within the Medicare Advantage market the effect would likely be felt most acutely by physicians who specialize in providing services to the elderly. With limited capacity to expand their business to traditional Medicare, these physicians may be especially harmed by the exceptionally high degree of concentration in the Medicare Advantage market where the lack of competition enables insurers to depress fees paid to physicians for services under Medicare Advantage.

OIR Should Reject the Application to Merge to Protect Consumers

Given that the proposed merger would result in countless highly concentrated commercial and Medicare Advantage markets where the merged entity either possessed substantial market shares or could exercise buyer power through coordinated interaction, it is critical for OIR to oppose the proposed merger so that consumers and physicians have adequate competitive alternatives. Unless the application is rejected, the merged entity would likely be able to raise premiums, reduce plan quality, and lower payment rates for physicians to a degree that would reduce the quality or quantity of services that physicians offer to patients.

MERGER EFFICIENCY CLAIMS ARE UNSUPPORTED AND SPECULATIVE

The NAIC Competitive Standard provides that a merger may be approved if "the acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or the acquisition will substantially increase the availability of insurance, and the public benefits of the increase exceed the public benefits which would arise from not lessening competition." This is a daunting test and reflects skepticism about efficiency defenses in merger cases also found in federal antitrust law.[53] ("The Supreme Court has never expressly approved an efficiencies defense to a section 7 claim….We remain skeptical about the efficiencies defense in general and about its scope in particular.")[54] Under the Horizontal Merger Guidelines, Aetna's claimed efficiencies are not to be credited unless they are "merger specific"—likely to be accomplished with the proposed merger and unlikely to be achieved in the absence of the merger. Also, claimed efficiencies must be "verifiable" and "cognizable," meaning parties asserting the existence of efficiencies bear the burden of substantiating them with evidence relating to their

[52] Id.
[53] See *St. Alphonsus Medical Center and Federal Trade Commission v. St. Luke's*, 778 F.3d 775 (9th Cir, 2015).
[54] Id.

likelihood and magnitude and how each efficiency would enhance the merged firm's ability and incentive to compete. Finally, benefits must be passed through to customers:

> The greater the potential adverse competitive effect of a merger, the greater must be the cognizable efficiencies, and the more they must be passed through to customers…When the potential adverse competitive effects of a merger is likely to be particularly substantial, extraordinarily great cognizable efficiencies would be necessary to prevent the merger from being anticompetitive.[55]

At the OIR hearing, Aetna met neither the NAIC Competitive Standard nor the Horizontal Merger Guidelines test for proving redeeming efficiencies. Aetna did not even identify, much less carry its burden of establishing, substantial economies of scale or economies in resource utilization. Aetna merely declares that it will achieve $1.25 billion in operating cost savings by 2018 and that it will achieve "more affordable care." However, management's testimony was notable for its lack of clarity on how any savings from the merger would be achieved. And as Professor Dafny noted in her Senate testimony, there is still the question of whether benefits will be passed through to consumers in light of that diminished competition."[56] Indeed Aetna's claim of more affordable care is undermined by the studies of consummated health insurance mergers discussed above, which show that the mergers actually resulted in harm to consumers in the form of higher, not lower, insurance premiums.

The most notable scale related testimony was from Aetna management who mentioned the challenges they would face operating a firm with the large size of the merged entity. Failing to identify any economy of scale, Aetna of course did not address how any such economy could not be feasibly achieved in any other way. In sum, Aetna made no effort at the hearing to show that the claimed savings is (1) verifiable; (2) merger specific; and (3) greater than the transaction's substantial anticompetitive effects.

Aetna claims in a slide presentation that the merger would yield broad and vaguely defined "value-based care arrangements," "broader choice of products, and better overall health care experience." Management also repeatedly testified that the merger is "complementary" in the sense that Humana has the larger Medicare Advantage business and Aetna the larger commercial footprint and "focus" in that market.

Aetna's claim of "value-based care arrangements" emerging from the merger was unsupported. Also absent was evidence as to why value-based arrangements if achieved through the merger, would be unlikely to be achieved in the absence of a merger. Perhaps explaining the lack of evidence is Professor Leemore Dafny's Senate hearing on this merger: "there is no evidence that larger insurers are more likely to implement innovative payment and care management programs…[and] there is a countervailing force offsetting this heightened incentive to invest in…reform: more dominant insurers in a given insurance market are less concerned with ceding market share."[57] In fact, "concerted delivery system reform efforts have tended to emerge from

[55] Horizontal Merger Guidelines, Section 10
[56] Id. at 16.
[57] Dafny, supra note 1, at 16.

other sources, such as provider systems…and non-national payers," according to Professor Dafny, not commercial health insurers.[58]

As for a claimed broader choice of products, consumers would have the broadest choice of products if both Aetna and Humana competed. No explanation was offered at the hearing as to why a merger was necessary to expand product offerings.

Also, Aetna made no effort to explain why Humana's having the larger Medicare Advantage business would help Aetna achieve an operating efficiency that could not be achieved without a merger. While a merger may be a quicker way for Aetna to gain market share in Medicare Advantage that now represents a smaller share of its business than commercial, to permit all such firms to satisfy their aspirations by horizontal merger could eviscerate competition.

Finally, the vague and unsubstantiated claim of a "better overall health experience" that Aetna would attribute to the merger cannot trump, under NAIC or federal merger standards, the adverse competitive effects that we have described earlier.

CONCLUSION

Any remedy short of rejecting the merger application would not adequately protect consumers. A divestiture would not protect against the loss of potential competition that occurs when one of the largest health insurers is eliminated. Moreover, divesture could be highly disruptive to the marketplace and cause harm to consumers, especially in Medicare Advantage markets where the elderly would be faced with a new insurer.

As a practical matter, the overwhelming number of markets adversely affected by the proposed merger, along with the barriers to entry to health insurance, makes unlikely that the OIR could find proposed buyers of assets that could supply health insurance at a cost and quality comparable to that of the merger parties in the huge number of affected markets. Moreover, any qualified purchaser able to contract with a cost competitive network of hospitals and physicians, if found, would likely already be a market participant, and a divestiture to such an existing market participant would not likely return the market to even pre-merger levels of competition.

Accordingly, AMA, FMA and FOMA respectfully urge the OIR to reject the parties' application to merge in order to protect consumers from premium increases, lower plan quality and a reduction in the quantity and quality of physician services.

[58] Id.

From: Claire McAndrew [CMcAndrew@familiesusa.org]
Sent: Thursday, December 17, 2015 2:29 PM
To: Anthem Hearing; Aetna Hearing
Cc: Joseph Patrick Ditré
Subject: Comments for FLOIR Merger Hearings
Attachments: Families USA Questions on Insurance Mergers for FLOIR.pdf

Attached please find comments from Families USA regarding the proposed health insurance mergers currently under FLOIR's review and open for comment through today, December 17, 2015.

Sincerely,

Claire McAndrew

Claire McAndrew
Private Insurance Program Director
202-628-3030
CMcAndrew@familiesusa.org

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

December 16, 2015

Commissioner Kevin McCarty
Florida Office of Insurance Regulation
200 East Gaines Street
Tallahassee, FL 32399

Families USA is non-profit, nonpartisan organization dedicated to the achievement of high-quality, affordable health coverage and care for all. While we take no position on the proposed health insurance mergers currently under consideration by the Florida Office of Insurance Regulation and the U.S. Department of Justice at this time, we urge the Florida Office of Insurance Regulation to carefully scrutinize the mergers to assess their impact on consumers' health care costs and access to services.

Specifically, we respectfully submit the following list of questions (originally submitted to the Department of Justice, but we believe largely applicable to the review taking place in Florida) and hope FLOIR will consider them when determining a course of action on proposed health insurance mergers. Should you have any questions or need further information, please contact Claire McAndrew at cmcandrew@familiesusa.org or Joe Ditre at jditre@familiesusa.org. Both individuals can also be reached at 202-628-3030.

Sincerely,

Claire McAndrew
Private Insurance Program Director

Joe Ditre
Senior Director of Enterprise and Innovation

FamiliesUSA.org
1201 New York Avenue, NW, Suite 1100
Washington, DC 20005
main 202-628-3030 / fax 202-347-2417

Questions to Consider for Consumer Protection Regarding Proposed Insurance Mergers

1. **Choice of plans and carriers**:
   How will the merger affect the entry of new insurers in each geographic area? Are new entrants likely to be financially viable? Please consider this in light of the fact that federal loans for CO-OP plans are no longer available. What impact, if any, will mergers have on the health insurance marketplaces created under the Affordable Care Act in terms of the number of carriers offering plans and the types of plans offered?
2. **Effect on premiums in each market:**
   How will the merger affect premium prices for individual insurance on the marketplace, small group insurance, large group insurance, and/or Medicare Advantage? In considering this, please keep the following factors in mind:
   a. Medical loss ratios are a helpful tool in the individual and small group markets, but they do not prevent all unreasonable price increases: If insurers increase premiums, they can also increase the dollar amount they retain for administration and profit. Are the merged insurers likely to increase both premiums and profits?
   b. Rate review at the state level can stop unreasonable price increases in the individual and small group markets, provided state law provides this authority. But will a merger create entities that are too powerful for regulators to effectively oversee? How will the proposed merger affect states that do not now review and reject unreasonable premium prices?
   c. What will mitigate against price increases in the large group market, since large group insurance is not subject to rate review requirements?
   d. Prices for Medicare Advantage plans are set through bids. If bids are higher than a federal benchmark, enrollees pay the difference in premium prices; if bids are lower than the benchmark, the federal government keeps part of the money and beneficiaries may also get supplemental benefits. Will a merger of Medicare Advantage plan sponsors likely increase costs to the federal government, increase costs to beneficiaries, or result in a reduction in supplemental benefits to enrollees?
3. **Savings to the consumer:**
   What portion, if any, of projected savings from each of these mergers will actually return to plan enrollees in the form of lower average premiums, lower out-of-pocket costs, or increased benefits or coverage?
   a. In determining the impact of these mergers on premium prices, what information can existing data about health plan premiums provide? Can data on premium prices for carriers that have strong negotiating power with providers currently indicate whether lower reimbursement rates to providers result in lower premiums for consumers?
   b. What evidence do previous health insurance mergers provide about the likelihood that consumers will directly benefit from any merger efficiencies? Can carriers assure that consumers will benefit from efficiencies?
4. **Access to providers:**
   What are the possible effects of these mergers on access to health care providers? Please especially consider whether they could cause a diminution of access to in-network providers that have not generally had strong negotiating power with insurers and to which consumers

often lack access, such as: outpatient mental health providers, pediatric specialists, and hospitals and other providers located in low-income communities.

5. **Post-merger conduct remedies:**
   Will the Department of Justice [or FLOIR] impose post-merger conduct remedies should either merger be approved and result in higher average premiums by plan type? Reduced benefits or coverage by plan type? Reduced number or breadth of provider networks? Blocked market entry?
6. **Consumer protections in a divestiture:**
   If divestitures are sought as a remedy, how will consumers be protected in the divestiture process? Will consumers have to leave their current plans? Will consumers be able to come back into those divested plans if they choose, and if so, how does this ensure that the merging (divested) plan does not have too much power in the market after the merger?
7. **Future health insurance consumer protections:**
   How will the mergers affect future health insurance regulation? State and federal regulators continue to work on rules implementing the Affordable Care Act, as well as other improvements to consumer protections. Will the mergers create entities that are too powerful to regulate?