STATEMENT

of the

American Medical Association and the Medical Association of Georgia

to the

Office of Insurance and Safety Fire Commissioner

RE: Aetna Application for the Proposed Acquisition of Humana

July 21, 2016

The American Medical Association (AMA) and the Medical Association of Georgia (MAG) appreciate the opportunity to provide comments regarding the 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 pose 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 in Georgia.

The AMA and MAG 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 also considered data on competition in health insurance in recent studies on the effects of health insurance mergers.

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 aspect 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] For these reasons, the AMA and MAG conclude that the proposed merger "would substantially lessen competition" in Georgia.[2] Accordingly, Aetna's application to acquire Humana should be denied.

[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] Ga. Code Ann., § 33-13-3.1

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

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

As discussed below, in Georgia the merger would substantially increase the market concentration of numerous already highly concentrated Medicare Advantage (MA) markets. Faced with these anticompetitive results, Aetna has argued that MA is in the same relevant market as traditional Medicare (TM) because consumers have the option of switching between MA and TM operated by the government.[3] This argument was recently flatly rejected in a letter authored by 20 prominent economists with expertise in the subjects of antitrust, competition policy, and health economics.[4] They reasoned that "the nature of the products and economic research leads to the conclusion that MA is not in the same relevant market as TM."[5]

As stated in the economists' letter, MA is substantially different than TM. In MA plans, Medicare pays most or all of the premiums to a private insurer.[6] Most MA plans are health maintenance organizations (HMOs).[7] In return for reduced choice of providers and utilization review, the Medicare beneficiary obtains more complete coverage. A Medicare beneficiary who wants to join an HMO has no other practical choice. TM is a very different type of plan than MA plans.[8] It has no panels and no serious utilization review.[9] Indeed, TM is the only surviving large-scale example of traditional indemnity insurance.[10]

TM provides unrestricted choice of provider but its benefit design exposes a beneficiary to risk of high out-of-pocket expenditures. In 2013-14, 16 percent of Medicare beneficiaries faced out-of-pocket expenditures that exceeded 20 percent of their annual income.[11] Purchase of a private Medicare supplement can reduce the risk of high out-of-pocket responsibilities, but at a fairly high cost.[12] MA insurance, on the other hand, leads to less risk of high out-of-pocket responsibilities. MA plans cover more services than TM and they are required to have an out-of-pocket maximum that limits the risk exposure of beneficiaries. In MA plans, the average out-of-pocket maximum was $5,014 per year per beneficiary in 2015.[13]

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[3] *See*, Testimony of Mark Bertolini, CEO of Aetna, United States Senate Committee on the Judiciary (September 22, 2015) at 5.
[4] See Exhibit 1, recently presented to the Florida Attorney General concerning the proposed Aetna-Humana merger.
[5] Id.
[6] *See,* Frech, H. E. III, 2016. Comments on Selected Issues Re: The Proposed Mergers of Anthem and Cigna and Aetna and Humana, submitted to the Departments of Insurance in California and Missouri (May 19) available at http://www.insurance.ca.gov/01-consumers/110-health/60- resources/upload/FrechReport-FINAL-051716-CA-002.pdf
[7] Id.
[8] Id.
[9] Id.
[10] Id.
[11] Id.
[12] Id.
[13] Id at 12-13.

Further, MA utilization control for hospitals appears to be quite strict, lending force to the idea that MA and TM are functionally different products.[14] A recent study has found that when MA beneficiaries had to switch to TM, their hospital utilization and costs rose substantially.[15] Consent decrees that the U.S. Department of Justice (DOJ) has entered into with Humana and Arcadian Management and with UnitedHealth Group and Sierra Health Services rightly observe that TM is not an adequate substitute for MA because MA plans offer substantially richer benefits at lower costs than TM, including lower copayments, lower coinsurance, caps on total yearly out-of-pocket costs, prescription drug coverage, and supplemental benefits that TM does not cover, such as dental and vision coverage, and health club memberships.[16] Moreover, in MA plans, seniors can receive a single plan covering a variety of benefits that seniors in TM must assemble themselves.

The combination of richer benefits and one-stop shopping accounts for the strong preference by many seniors for MA plans. Seniors are not likely to switch away from MA plans to TM in sufficient numbers to make an anticompetitive Aetna price increase or reduction in quality unprofitable. Over the long-term, MA plans are slowly increasing in share, attracting 31 percent of Medicare beneficiaries in 2015.[17] Research is consistent with the idea that beneficiaries treat MA plans as distinctly preferable to TM. Analysis of MA enrollees who were terminated because their plan left the market overwhelmingly (95 percent) actively sought another MA plan.[18]

Consequently, the closest competition to one MA insurer's plan is another insurer's MA plan and the presence of many competing MA insurers is what keeps quality and price competitive. This conclusion is buttressed by a recent study finding that when Humana offers a MA plan in the same county as Aetna, Aetna's premium is lower than in counties where Humana does not offer a plan.[19]

Additional research indicates that where there are fewer MA insurers, premiums are higher, showing that neither TM nor commercial insurance is a serious constraint on MA pricing, regardless of the number or concentration of other insurers in that market.[20]

In sum, Aetna and Humana compete for consumers in an MA product market that is separate and distinct from TM. This was the conclusion reached by the Missouri Department of Insurance on Aetna's application to acquire Humana. After considering an exhaustive record that included the comments of consumer and provider groups and the testimony of the merging parties and a

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[14] Id. at 13.
[15] Id at 13.
[16] United States v. Humana and Arcadian Management, 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). Paragraph 2.
[17] *See,* Comments of Prof. Frech at 12
[18] Id. at 13.
[19] Spiro, Topher, Maura Calsyn and Meghan, O'Toole. 2016. Bigger is not Better: Proposed Insurer Mergers are Likely to Harm Consumers and Taxpayers. Center for American Progress (Jan. 21, 2016).
[20] *See,* Comments of Prof. Frech at 13-14.

prominent expert health economist, MIT Professor Jonathan Gruber,[21] the department found that MA satisfies all of the practical indicia of a relevant antitrust product market.[22]

The conclusion that MA is a relevant market also avoids Aetna's dubious characterization of the government as an Aetna competitor attempting to compete for Medicare business. Instead the government is a purchaser procuring competitive bids from private health insurers competing to offer MA plans to Medicare beneficiaries.[23] Congress's goal in establishing the MA program was "that vigorous competition among private MA insurers…would lead those insurers to offer seniors a wider array of health insurance choices and richer and more affordable benefits than TM does, and be more responsive to seniors."[24] In the event Aetna were to acquire Humana, and competition for the government contract and MA beneficiaries were lessened, the government would actually be harmed – not advantaged, as would be the case if it were a competitor – by the higher prices and/or poorer service offered by a combined Aetna/Humana in MA.[25]

Tests to Measure Anticompetitive Effects

Competition is likely to be greatest when there are many sellers, none of which have any significant market share. Unfortunately, MA markets in Georgia are "highly concentrated," meaning that the size, size distribution and number of firms in these markets raise substantial risks that a merged Aetna/Humana would substantially lessen competition.

There are at least two ways of measuring market concentration and the degree of danger to competition that a merger poses. One test, adopted by the 2015 National Association of Insurance Commissioners Model Insurance Holding Company System Regulatory Act (NAIC Model Act), looks to the four firm concentration ratio (CR4). This concentration ratio is calculated by summing the market shares of the four largest insurers in the market. Georgia employs the CR4 test.

A different test is adopted by the federal enforcement agencies in their 2010 DOJ and Federal Trade Commission Horizontal Merger Guidelines (Horizontal Merger Guidelines). These federal guidelines use the Herfindahl–Hirschman Index (HHI) to measure market concentration. 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 higher than 2500 are highly concentrated.

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[21] Gruber, Jonathan. 2016. Report to the Missouri Department of Insurance regarding Competition in the Medical Advantage and Individual Exchange Markets (May 6) available at http://insurance.mo.gov/documents/exhibit-34.pdf

[22] *See* Findings of Fact, Conclusions of Law and Order, Missouri Department of Insurance, In Re Division of Insurance Company Regulation v. Aetna Inc. and Humana Inc.(May 24, 2016) (Exhibit B)

[23] For an explanation of the competitive bidding process, See Song, Landrum and Chernew, "Competitive Bidding and Medicare Advantage: Effect of Benchmark Changes Unplanned Bids", Journal of Health Economics 32 (2013) 1301-1312. http://www.ncbi.nlm.nih.gov/pubmed/24308881 .

[24] *See*, United States v. Humana and Arcadian Management, No. 12-cv-00464 (D.D.C. Mar. 27, 2012) (complaint) (*avail. at* http://www.justice.gov/atr/case-document/file/499076/download)

[25] A Center for American Progress Study has concluded that Medicare program spending would increase as a result of the merger. Spiro, Calsyn, O'Toole, "Bigger is not Better: Proposed Insurer Mergers are Likely to Harm Consumers and Taxpayers," Center for American Progress (Jan. 21, 2016)

The AMA and MAG have determined that under either method above for measuring concentration, all of Georgia MA markets are highly concentrated. Moreover, as explained below, the Aetna/Humana merger would increase the concentration of numerous already-concentrated health insurance markets to the extent that under the Georgia CR4 test the merger creates a prima facie violation of the Georgia competitive standard and under the Horizontal Merger Guidelines, the merger would be presumed likely to enhance market power.

In a Statewide Market, the Merger Violates Both the Horizontal Merger Guidelines and the Georgia Competitive Standard for Medicare Advantage

Under the Georgia competitive standard, a highly concentrated market is one in which the sum of the market shares of the four largest insurers – the so-called four-firm concentration ratio – is 75 percent or more of the market. The AMA has calculated that the combined shares of the four largest MA insurers in a Georgia statewide market total a whopping 91.8 percent, dwarfing by comparison the national four firm concentration ratio for airlines of 62 percent.[26] In such a highly concentrated Georgia MA market, there is a prima facie violation of the Georgia competitive standard when a firm with a 10 percent or more market share merges with a firm with a two percent or more market share. In the instant case, a prima facie violation of the Georgia competitive standard is easily established: Aetna's share is six percent and Humana's is 22 percent.[27] The merger would also run afoul of the Horizontal Merger Guidelines since Georgia's MA market has an HHI of 3873 (and thus is highly concentrated) and the increase in the HHI caused by the merger would be 258.[28]

In Several Metropolitan Statistical Areas, the Merger in the MA Market Would Again Run Afoul of Both the Horizontal Merger Guidelines and the Georgia Competitive Standard

In a number of Metropolitan Statistical Areas (MSA) for MA in Georgia, the merger of Aetna and Humana is presumed likely to enhance market power under the Horizontal Merger Guidelines. Even pre-merger, these Georgia MSAs are all highly concentrated with HHIs over 2500.[29] In the Brunswick MSA, the post-merger HHI market concentration would be 4849, for an increase of 870 points. Similarly, in the Savanna market the post-merger HHI would be 3592 with a 519 point increase; Atlanta-Sandy Springs-Marietta would have an HHI of 3314 with a 383 point increase; and Macon would have an HHI of 5453 with a 214 point increase.[30] Moreover, in each of the aforementioned MSAs, as well as in the Augusta-Richmond County GA-SC MSA, the merger would violate the Georgia competitive standard, meaning that in all of

[26] AMA analysis of HealthLeaders-InterStudy (HLI) data from 2013; HLI obtained the data from the Centers for Medicare & Medicaid Services., see Table 1; Dafny, supra note 1
[27] See Table 1; based on AMA analysis at footnote 26.
[28] See Table 2; based on AMA analysis at footnote 26.
[29] Following the example of DOJ, the AMA has measured market concentration by using the HHI. 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 Horizontal 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.
[30] See Table 3, based on AMA analysis at footnote 26.

them the shares of the four largest insurers, total 75 percent or more, Humana's market share is 10 percent or more and Aetna's is two percent or more.[31]

Note also that, in the Augusta-Richmond County, GA-SC MSA, the Aetna-Humana merger potentially raises significant competitive concerns, the kinds of which often warrant scrutiny under the Horizontal Merger Guidelines.[32]

In sum, under both the Horizontal Merger Guidelines and the Georgia competitive standard, the merger would create market structures that would likely result in anticompetitive effects. Consequently, the merger should not be approved.

THE PROPOSED MERGER’S ANTICOMPETITIVE EFFECTS IN COMMERCIAL HEALTH INSURANCE MARKETS

<u>In a Statewide Market, the Merger with Respect to Commercial Health Insurance Markets Violates the Georgia Competitive Standard and Potentially Raises Significant Competitive Concerns under the Horizontal Merger Guidelines</u>

Under the Georgia competitive standard, the combined shares of the four largest insurers in a Georgia statewide commercial health insurance market total 87.1 percent, so the statewide market is thus highly concentrated. Under the competitive standard, a prima facie violation is easily established: Aetna’s share is seventeen percent and Humana’s is five percent.[33]

The merger also raises significant competitive concerns statewide under the Horizontal Merger Guidelines since Georgia’s commercial health insurance market has a pre-merger HHI of 2127, which would increase by 153 points to 2280 if the merger is consummated.[34]

<u>With Respect to Certain MSA, the Proposed Merger Regarding Commercial Health Insurance Would Run Afoul of the Georgia Competitive Standard and the Horizontal Merger Guidelines.</u>

In a number of MSA’s in Georgia, i.e., the Macon, Atlanta-Sandy Springs-Marietta, Rome, Gainesville, and Athens-Clarke County MSAs, the merger of Aetna and Humana would violate the Georgia competitive standard. In all of these MSAs the shares of the four largest insurers total 75 percent or more, and (1) Humana’s market share is 10 percent or more and Aetna’s is two percent or more, or (2) Aetna’s market share is 10 percent or more and Humana’s is two percent or more.[35]

Moreover, the proposed merger would be presumed likely to enhance market power under the

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[31] See Table 4, based on AMA analysis at footnote 26.
[32] See Table 5, based on AMA analysis at footnote 26.
[33] See Table 6
[34] See Table 7
[35] See Table 8

federal Horizontal Merger Guidelines in the Macon MSA, where the post-merger HHI would be 2819 with a 604 point increase.[36]

<u>In a Number of Other MSAs, the Proposed Merger with Respect to Commercial Health Insurance Potentially Raises Significant Competitive Concerns under the Horizontal Merger Guidelines.</u>

In additional MSAs, i.e., the Rome, Gainesville, Atlanta-Sandy Springs-Marietta, and Athens-Clarke County MSAs, the proposed merger potentially raises significant competitive concerns that often warrant scrutiny under the Horizontal Merger Guidelines.[37]

BARRIERS TO ENTRY

The market share and concentration data do not overstate the mergers' future competitive significance in health insurance and physician markets. This is not a case where new market entry could defeat an exercise of monopoly or monopsony power. Instead, lost competition through a merger of health insurers 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 state and federal regulatory requirements; 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.[38] In addition, a DOJ study of entry and 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."[39] Finally, AMA's own analysis of MSA data from its *Competition in Health Insurance* studies show that in the numerous Georgia MSAs where the merger would be anticompetitive in commercial markets, the market shares and ranking of market leaders have also been durable and little changed from 2010 thru 2013, the most recent timeframe for which we have data.[40]

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 significant business – volume discounting that reflects a reduction in transaction costs and greater budget certainty. Hence, incumbent insurers have a durable cost advantage.

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[36] See Table 9

[37] See Table 10

[38] *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 (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).

[39] 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.

[40] See Tables 11 and 12

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. Substantial evidence was introduced in those hearings, showing that replicating the Blues' extensive provider networks constituted a major barrier to entry. The evidence further demonstrated that there has been very little in the way of new entry that might compete with the dominant Blues Plans in the Pennsylvania health insurance markets. In a report commissioned by the Pennsylvania Insurance Department, 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.[41]

The merging health insurers have argued that times have changed and the health insurance marketplaces have made entry easy. The facts, however, do not bear out that claim. Recent state developments only highlight the barrier to entry problem. According to the Kaiser Health News of July 13, 2016, only seven of the 23 ACA insurance co-ops, subsidized by millions of dollars in government loans, will be open for business in the fall.[42] The quick decline of these co-ops illustrate that even with heavy federal subsidies, health insurance is a tough business to enter.

THE PROPOSED MERGER IS LIKELY TO HARM CONSUMERS

We have evaluated the potential effects of the proposed megamerger on both (1) the sale of MA products to individuals (the sell side); and (2) the purchase of health care provider (including physician) services (the buy side).[43] The AMA and MAG have concluded that on the sell side, the merger is likely to result in higher premium levels to MA recipients and purchasers of commercial health insurance and/or a reduction in the quality of health insurance that can take several forms, including, for example, a reduction in the availability of providers or lower quality consumer service. 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 those physicians are able to offer patients.

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

[42] "Seven Remaining Obamacare Co-Ops Prepare Survival Strategies," Kaiser Health News, July 13, 2016, available at http://khn.org/news/seven-remaining-obamacare-co-ops-prepare-survival-strategies/

[43] 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.

LIKELY DETRIMENTAL EFFECTS FOR CONSUMERS

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.[44] More 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 percent relative to a control group. These findings suggest that the merging parties exploited their resulting market power, to the detriment of consumers.[45] Also, recent studies suggest premiums for employer-sponsored fully-insured plans are rising more quickly in areas where insurance market concentration is increasing.[46]

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.[47] 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 percent, while the inclusion of all companies in the individual insurance markets could have lowered rates by 11.1 percent.[48] 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 MA.[49]

Plan Quality

The proposed merger can be expected to adversely affect MA and commercial health insurance product quality. MA plans and commercial health 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 MA plans and commercial health insurers 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

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[44] Leemore Dafny et al, "Paying a Premium on your Premium? Consolidation in the US health insurance industry," *American Economic Review* 2012; 102: 1161-1185.
[45] 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.
[46] Dafny, supra note 1, at 11.
[47] Dafny et al., supra note 1, at 11.
[48] 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.
[49] Dafny supra note 1, at 11.

hospitals where, given their restricted network plans, many of the hospitals' physicians will not have been offered a contract by the MA plan or commercial health insurer.

While the relationship between insurer consolidation and plan quality requires additional research, one study in the MA market found that more robust competition was associated with greater availability of prescription drug benefits.[50] As Professor Dafny observes, "the competitive mechanisms linking diminished competition to higher prices operate similarly with respect to lower quality."[51]

Medical Loss Ratio is No Substitute for Competition

The Affordable Care Act (ACA) requires insurers to meet minimum medical loss ratios (MLR) of 80% in the individual and small group market and 85% in the large group market. The existence of these ratios should not carry any weight in determining whether to challenge the Aetna/Humana merger.

We and others have exhaustively explained MLR's myriad of limitations in protecting consumers from anticompetitive premium increases.[52] Perhaps the most compelling statement of why MLR should not become an excuse for approving otherwise anticompetitive insurance mergers is found in a July 8, 2016 letter from several consumer organizations to Florida Attorney General Pam Bondi.[53] That letter reflects the views of Washington and Lee University School of Law Professor Emeritus Timothy Jost, who worked extensively on the National Association of Insurance Commissioners' MLR rule.

As Professor Jost explains, the ACA's MLR requirements impose a minimum, not an optimal, floor on insurers' expenditures for claims and quality improvement activities. It does not prevent insurers with market power from spending less on claims and taking more in profits than they would have in a competitive market. Also, MLR does not address the non-price or quality dimensions of insurance coverage that would prevent the exercise of market power through decreasing quality (such as the responsiveness of consumer services, or the adequacy of networks or willingness to innovate in providing better quality coverage to consumers). The MLR does not perform a regulatory function comparable to utility regulation or other regulations designed to limit monopoly pricing. Finally, MLR does not protect employees of self-funded employers, who constitute the majority of covered employees, and suffers from other limitations outlined in the July 8, 2016, letter of consumer representatives, as advised by Professor Jost.

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[50] Robert Town and Su Liu, "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* (2003): 719-736.
[51] Dafny supra, note 1 at 11.
[52] James L. Madara, MD, Executive Vice President, American Medical Association letter to the Hon. William Baer, Assistant Attorney General, United States Department of Justice, Antitrust Division, (November 11, 2015) at page 12 ; Melinda Hatton, Senior Vice President and General Counsel, American Hospital Association letter to Ted Nichel, Wisconsin Insurance Commissioner and Katherine Wade, Connecticut Insurance Commissioner (February 23, 2016) (Exhibit 2); Leemore Dafny, "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?", Testimony before the Senate Committee on the Judiciary, (September 22, 2015) at 10.
[53] See Exhibit 3, recently presented to the Florida Attorney General concerning the proposed Aetna-Humana merger.

THE MONOPSONY POWER ACQUIRED THROUGH THE MERGER WOULD LIKELY DEGRADE THE QUALITY AND REDUCE THE QUANTITY OF PHYSICIAN SERVICES

Just as the merger would enhance market power on the sell side of the MA and commercial health insurance markets, it would also enhance monopsony or buyer power in the purchase of inputs such as physician services, thereby eviscerating physicians' ability to contract with alternative MA plans and commercial health 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, "[M]onopsony 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."[54] She further explained that the "textbook monopsony scenario…pertains when there is a large buyer and fragmented suppliers."[55] 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.[56]

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 to anticompetitive levels.[57] This is because physicians could not readily replace lost business by refusing the insurer's contract and dealing with other payers without suffering irretrievable lost income.[58] It is difficult to convince consumers (which in many cases are employers) to switch to different health insurers.[59] Also, switching health insurers is a very difficult decision for physicians because it impacts their patients and disrupts their practice. The patient-physician relationship is a very important aspect to the delivery of high-quality healthcare. And it is a very serious decision both personally and professionally for physicians to disrupt this relationship by dropping a health insurer. 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 if the direct prices paid by subscribers do not increase.[60]

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[54] Dafny, supra note 1, at 10.
[55] Id.
[56] Carol K. Kane, PhD., American Medical Association Policy Research Perspectives: Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership, July 2015.
[57] Comments of Prof. Frech at 7 ("…the threat of losing even a small percentage of commercially-insured volume may allow an insurer to reduce prices or gain other contractual benefits. Therefore, buyer-side market power is likely to be a problem at lower concentration levels than on the seller side.")
[58] See Capps, Cory S., Buyer Power in Health Plan Mergers (June 2010). Journal of Competition Law and Economics, Vol. 6, Issue 2, pp. 375-391.
[59] See e.g. *U.S. v. UnitedHealth Group and Pacificare Health Systems*., Complaint, No. 1:05CV02436, ¶ 37 (December 20, 2005), available at http://www.justice.gov/file/514011/download. (As alleged in the United/PacifiCare complaint, physicians encouraging patients to change plans "is particularly difficult for patients employed by companies that sponsor only one plan because the patient would need to persuade the employer to sponsor an additional plan with the desired physician in the plan's network" or the patient would have to use the physician on an out-of-network basis at a higher cost).
[60] *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

In another 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."[61]

The DOJ's monopsony challenges properly reflect its 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."[62] Health insurer monopsonists typically are also monopolists.[63] 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,[64] 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 provider networks for consumers who depend on these networks for access to quality healthcare."[65] The Pennsylvania Insurance Department further concluded:

> [O]ur 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.[66]

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

conduct does not adversely affect the ultimate consumers who purchase the end-product), available at: http://www.usdoj.gov/atr/public/spceches/3924.wpd.

[61] 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.

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

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

[64] 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.

[65] *See* Statement of Pennsylvania Insurance Commissioner Joel Ario on Highmark and IBC Consolidation (January 22, 2009).

[66] Id.

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. 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.[67] Recent projections by the Health Resources and Services Administration similarly suggest a significant shortage of primary care physicians in the United States.[68]

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.[69] According to the Deloitte survey, 57 percent of physicians also said that the practice of medicine was in jeopardy and nearly 75 percent 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.[70]

Likewise, the reduction in the number of MA plans and commercial health insurers would create MA plan and commercial health insurer oligopolies that, through coordinated interaction, can exercise buyer power. Indeed, the setting of payment 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.

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[67] *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.

[68] *See* Health Resources and Services Administration, Projecting the Supply and Demand for Primary Care Physicians through 2020 in Brief (November 2013).

[69] Deloitte 2013 Survey of U.S. Physicians: Physician perspectives about health care reform in the future of the medical profession.

[70] Id.

MAG Survey Results

A 2016 MAG survey explored the monopsony issue, guided by the following principle: that a loss of competition on the buy side can occur within the localized geographic markets for the purchase of physician services when the merging health insurers hold contracts with a significant number of physicians who are financially dependent on contracting with the merging health plans.[71] This is precisely the case in a merger of Aetna with Humana. Seventy-two percent of physician respondents to the MAG survey felt they *had* to contract with Aetna in order to have a financially viable practice; and 62 percent felt that way with respect to Humana.

While these percentages are indicative of monopsony power, the merger promises to make matters much worse. Eighty-four percent of responding physicians said that the merger of Aetna with Humana would make the process of contract negotiations less favorable for physicians.

When asked if they had seen an "an all products clause" – a clause in the health plan physician contract that requires, as a condition of participating in any of the health plan products, that the physician participate in all of the health plan products – 67 percent reported that they had. Such bundling would not offer any promise of efficiencies and should be viewed with disfavor by anyone interested in fostering competitive markets.

Physicians responding to the MAG survey also identified by very large percentages a number of anticompetitive effects likely to occur in the event of an Aetna/Humana merger:

- An astonishing 93 percent of physician decision-makers said that there would be a reduction in the quality and quantity of the services that physicians are able to offer their patients; and

- 78 percent reported that they will be *very or somewhat likely* pressured *not* to engage in aggressive patient advocacy as a result of the merger.

The extent of the merged entity's monopsony power and how it may ultimately injure consumers is also revealed in physician responses to the question of whether there would be any consequences in not continuing to contract with the merged firm:

- 42 percent would cut investments in practice infrastructure;

- 45 percent would cut or reduce staff salaries;

- 42 percent would have to spend less time with patients; and
- 29 percent would cut quality initiatives or patient services.

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[71] Christine White, Sarahlisa Brau, and David Marx, Antitrust and Healthcare: A Comprehensive Guide, at 163 (2013); see also Capps, Cory S., Buyer Power in Health Plan Mergers (June 2010). Journal of Competition Law and Economics, Vol. 6, Issue 2, pp. 375-391; and U.S. Dep't of Justice and Fed. Trade Comm'n, Horizontal Merger Guidelines, supra 1, at page 33; Federal Trade Commission and U.S. Department of Justice, Improving Health Care: A Dose of Competition (July, 2004), at 15.

MERGER EFFICIENCY CLAIMS ARE UNSUPPORTED AND SPECULATIVE

Professor Dafny noted in her Senate testimony that claims of offsetting efficiencies cannot ameliorate the competitive harm from these mergers. "Efficiencies must be merger-specific and verifiable…and there is still the question of whether benefits will be passed through to consumers in light of that diminished competition."[72] Insurers have a dismal track record of passing any savings from an acquisition on to consumers, and there is no reason to believe that this transaction would be any different. Under these circumstances, we suggest that the Office of Insurance and Safety Fire Commissioner review the merging insurers' efficiency claims with skepticism similar to that expressed by the Ninth Circuit Court of Appeals in the merger case of *St. Alphonsus Medical Center and Federal Trade Commission v. St. Luke's*, 778 F.3d 775 (9th Cir, 2015). ("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.")[73]

Turning to the health insurers' specific efficiency claims,

> [T]here 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 due to their dominance.[74]

In fact, "concerted delivery system reform efforts have tended to emerge from other sources, such as provider systems…and non-national payers," according to Professor Dafny, not from commercial health insurers.[75]

In any event, the vague "innovative payment" and "care management" claims that the health insurers have made in support of the merger are 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.

TO PROTECT CONSUMERS, THE DEPARTMENT OF INSURANCE SHOULD REJECT THE APPLICATION TO MERGE

Given that the proposed merger would increase concentration even further in Georgia's MA and commercial health insurance markets, where the merged entity would either possess substantial market shares or could exercise buyer power through coordinated interaction, it is critical for the Office of Insurance and Safety Fire Commissioner to oppose the proposed merger so that consumers and physicians have adequate competitive alternatives. Unless the application is

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[72] Dafny, supra note 1, at 16.
[73] *St. Alphonsus Medical Center and Federal Trade Commission v. St. Luke's*, 778 F.3d 775, 789-790 (9th Cir, 2015)
[74] Dafny, supra note 1, at 16.
[75] Id.

rejected, the merged entity would likely be able to raise premiums in the MA and commercial health insurance markets, reduce plan quality, and lower payment rates for physicians to a degree that would reduce the quality or quantity of services that physicians can offer to patients.

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 in MA markets where the elderly would be faced with a new insurer, and patient-physician relationships would be disrupted in commercial health insurance markets.

As a practical matter, the number of markets adversely affected by the proposed merger, along with the barriers to entry to health insurance, makes it unlikely that the Office of Insurance and Safety Fire Commissioner 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 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, the AMA and MAG respectfully urge the Office of Insurance and Safety Fire Commissioner to reject the parties' application to merge in order to protect Georgia consumers from premium increases, lower plan quality, and a reduction in the quantity and quality of physician services.

Competition in Georgia Medicare Advantage (MA) Markets
Analysis of Data from HealthLeaders-InterStudy's Managed Market Surveyor 2013
Effects of Aetna-Humana Merger[76]

Table 1. Four-Firm Concentration Ratio and Largest Insurers' MA Market Shares in Georgia, 2013

Insurer	Market Share	Rank by Share	Concentration Ratio
UnitedHealthcare	57	1	91.8
Humana	22	2	
WellCare	6	3	
Aetna	6	4	

Table 2. Statewide Data Showing Aetna/Humana Merger will be Presumed Likely to Enhance Market Power in the MA Market in Georgia, 2013

	MA HHI	Post-Merger HHI	Change in HHI
Georgia	3873	4131	258

Table 3. Georgia MSAs where an Aetna/Humana Merger Will Be Presumed Likely to Enhance Market Power in the MA Market, 2013

MSA	MA HHI	Post-Merger HHI	Change in HHI
Brunswick, GA	3979	4849	870
Savanna, GA	3073	3592	519
Atlanta-Sandy Springs-Marrietta, GA	2931	3314	383
Macon, GA	5239	5453	214

[76] AMA's study analyzes data from the HealthLeaders-InterStudy (HLI) Managed Market Surveyor, © 2013. HLI obtained the data from CMS. We exclude HCPP, PACE, employer-only and SNP-only plans.

Table 4. Four-Firm Concentration Ratios and Aetna's and Humana's MA Market Shares in MSAs where an Aetna-Humana Merger Will Be Presumed Likely to Enhance Market Power, 2013

MSA	Insurer	Pre-Merger Share	Rank by Share	CR4
Brunswick, GA	Humana	23	2	100.0
	Aetna	19	3	
Savanna, GA	Humana	26	2	98.0
	Aetna	10	4	
Atlanta-Sandy Springs-Marietta, GA	Humana	23	2	88.3
	Aetna	8	5	
Macon, GA	Humana	21	2	100.0
	Aetna	5	3	
Augusta, Richmond County GA-SC	Humana	31	2	98.2
	Aetna	3	4	

Table 5. Aetna-Humana Merger Effects on MA Market Concentration in Georgia MSA where Merger Potentially Raises Significant Competitive Concerns and Often Warrants Scrutiny, 2013

State/MSA	Pre-Merger HHI	Post-Merger HHI	Change in HHI
Augusta-Richmond County, GA-SC	4292	4461	169

Competition in Georgia Health Insurance Markets
Data from AMA's Competition in Health Insurance, 2015 Update
Effects of Aetna-Humana Merger on Georgia Commercial Product Markets[77]

Table 6. Four-Firm Concentration Ratio and Largest Insurers' Market shares in Georgia, 2013

Insurer	Market Share	Rank by Share	Concentration Ratio
WellPoint	30	1	87.1
UnitedHealthcare	26	2	
Aetna	17	3	
Cigna	14	4	
Kaiser	5	5	
Humana	5	6	

Table 7. Aetna-Humana merger Effects on Market Concentration in Georgia—where the Merger Potentially Raises Significant Concerns and Often Warrants Scrutiny, 2013

	Total HHI	Total HHI post-merger	Change in HHI
Georgia	2127	2280	153

Table 8. Four-Firm Concentration Ratios Applicable to Georgia MSAs, 2013

MSA	Insurer	Pre-Merger Share	Rank by Share	CR4
Rome, GA	Aetna	14	5	82.3
	Humana	14	4	
Gainesville, GA	Aetna	11	5	77.2
	Humana	13	3	
Atlanta-Sandy Springs-Marietta, GA	Aetna	20	3	85.5
	Humana	5	6	
Athens-Clarke County, GA	Aetna	6	6	81.7
	Humana	11	3	
Macon, GA	Aetna	18	3	88.6
	Humana	17	4	

[77] AMA's study analyzes data from the HealthLeaders-InterStudy Managed Market Surveyor, © 2013. *Commercial* products in this study include HMO, PPO and POS plans.

Table 9. Aetna-Humana Merger Effects on Market Concentration in Georgia MSA—where Merger Will Be Presumed Likely to Enhance Market Power, 2013

State/MSA	Pre-Merger HHI	Post-Merger HHI	Change in HHI
Macon, GA	2215	2819	604

Table 10. Aetna-Humana Merger Effects on Market Concentration in MSAs-- where the Merger Potentially Raises Significant Concerns and Often Warrants Scrutiny, 2013

MSA	Pre-Merger HHI	Post-Merger HHI	Change in HHI
Rome, GA	1982	2385	402
Gainesville, GA	1889	2169	280
Atlanta-Sandy Springs-Marietta, GA	2032	2249	217
Athens-Clarke County, GA	2265	2394	129

Table 11. Market Share Trends of the Four Largest Insurers in Georgia MSA Where an Aetna-Humana Merger will be Presumed Likely to Enhance Market Power, 2010-2013

MSA	Insurer	Market Shares			
Macon, GA		2010	2011	2012	2013
	WellPoint	40	38	39	34
	UnitedHealthcare	26	25	24	20
	Aetna	11	11	9	18
	Humana	6	7	8	17

Table 12. Market Share Trends of the Largest Insurers in Georgia and MSAs—Where an Aetna-Humana Merger Potentially Raises Significant Competitive Concerns and Often Warrants Scrutiny, 2010-2013

MSA	**Insurer**	**Market Shares**			
Georgia		2010	2011	2012	2013
	WellPoint	33	31	32	30
	UnitedHealthcare	27	27	27	26
	Aetna	13	13	12	17
	Cigna	12	13	13	14
	Kaiser	5	6	5	5
	Humana	3	3	4	5
Rome, GA	WellPoint	36	33	33	28
	UnitedHealthcare	27	26	25	20
	Cigna	14	16	16	20
	Humana	8	8	9	14
	Aetna	13	13	12	14
Gainesville, GA	WellPoint	34	33	33	30
	UnitedHealthcare	27	28	26	23
	Humana	4	4	6	13
	Cigna	11	11	13	11
	Aetna	7	7	7	11
Atlanta-Sandy Springs-Marietta, GA	WellPoint	29	27	28	27
	UnitedHealthcare	25	26	26	25
	Aetna	17	16	15	20
	Cigna	11	12	13	14
	Humana	5	4	5	5
Athens-Clarke County, GA	WellPoint	42	42	42	37
	UnitedHealthcare	26	28	26	22
	Humana	2	3	5	11
	Athens Hlth Plan	15	14	12	11
	Cigna	5	6	8	9
	Aetna	4	4	3	6