

**STATEMENT**  
**of the**  
**American Medical Association**  
**and the**  
**California Medical Association**  
**to the**  
**California Department of Insurance**

**RE:    Anthem Application for the Proposed Acquisition of Cigna**

**March 29, 2016**

The American Medical Association (AMA) and California Medical Association (CMA) appreciate the opportunity to provide comments regarding Anthem's application for the proposed acquisition of Cigna. We believe that high insurance market concentration is an important issue of public policy because insurer 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. 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. On the buy side, the merger 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."<sup>1</sup> For these reasons we conclude that, the proposed merger "would substantially lessen competition."<sup>2</sup> And we ask that, Anthem's application to acquire Cigna be denied.<sup>3</sup>

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<sup>1</sup> 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 (Dafny's Senate Testimony).

<sup>2</sup> Cal.Ins.Code § 1215.2 (d)( 2)

<sup>3</sup> Id.

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

### *The Significance and Measurement of Market Concentration*

Competition is likely to be greatest when there are many sellers, none of which have any significant market share. Unfortunately, markets for commercial health insurance in California are “highly concentrated”, meaning that the size, size distribution and number of firms in these markets raise substantial risks that a merged Anthem/Cigna 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.

A different test is adopted by the federal enforcement agencies in their 2010 Federal Trade Commission (FTC) and Department of Justice (DOJ) 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. Oddly, Anthem’s competitive effect testimony omits any discussion of market concentration and its increase. The AMA, however, has determined that under either method for measuring concentration, numerous highly populated California health insurance markets are concentrated or highly concentrated. Moreover, as explained below, the Anthem/Cigna merger would increase the concentration of numerous already concentrated health insurance markets to the extent that under the NAIC CR4 test the merger creates a *prima facie* violation of the NAIC competitive standard and under the Horizontal Merger Guidelines, the merger would be presumed likely to enhance market power.

### *In a Statewide Market, Merger Violates NAIC Competitive Standard.*

Under the NAIC CR4 test, 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% or more of the market. Utilizing data obtained from HealthLeaders-Interstudy Managed Market Surveyor from January 1, 2013 (hereafter HLI data), the AMA’s health economists have determined the combined shares of the four largest commercial health insurers in a California statewide market total a whopping 80.8%, dwarfing by comparison the national four firm concentration ratio for airlines of 62%.<sup>4</sup> In such a highly concentrated state health insurance market, there is a *prima facie* violation of the NAIC CR4 test (its Competitive Standard) when a firm with a 10% market share merges with a firm with a 2% or more market share. In the instant case, a *prima facie*

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<sup>4</sup> Dafny, *supra*. (

violation of the NAIC Competitive Standard is easily established: Anthem's share is 29% and Cigna's is 5%.<sup>5</sup>

*With Respect to Metropolitan Statistical Areas, the Merger Would Again Run Afoul of Both the Federal Antitrust Merger Enforcement Guidelines and the NAIC Competitive Standard*

The result is no different if we consider the competitive effect of the merger in metropolitan statistical areas within the state of California.<sup>6</sup> Utilizing data obtained from HealthLeaders-Interstudy Managed Market Surveyor from January 1, 2013, the AMA has determined, in accordance with the Horizontal Merger Guidelines, the commercial health insurance market concentrations and change in market concentrations that would result from the merger. The AMA analysis shows that an Anthem acquisition of Cigna would be presumed likely, under the Horizontal Merger Guidelines, to enhance market power in the following highly populated commercial health insurance markets: Santa Cruz-Watsonville; Santa Ana-Anaheim-Irvine; Santa Barbara-Santa Maria; Salina's; Oxnard-Thousand Oaks-Ventura; Los Angeles-Long Beach-Glendale; Bakersfield; El Centro; and Modesto.<sup>7</sup> Moreover, in each of the aforementioned populous MSAs, the merger would violate the NAIC Competitive Standard, meaning that in all of them the shares of the four largest insurers total 75% or more, Anthem's market share is 10% or more and Cigna's is 2% or more.<sup>8</sup>

There are also additional heavily populated MSAs where, under the Horizontal Merger Guidelines, the merger potentially raises significant competitive concerns. They include: San Jose-Sunnyvale-Santa Clara; San Diego-Carlsbad-San Marcos; San Francisco-San Mateo-Redwood City; Riverside-San Bernardino-Ontario; Oakland-Fremont-Hayward; and Sacramento-Arden-Arcade-Roseville.<sup>9</sup>

When the NAIC Competitive Standard is applied to the merger in these markets, it is *prima facie* anticompetitive in all but one of them. (In San Diego-Carlsbad –San Marcos, the four firm concentration ratio misses the 75% threshold by a hair. It is 72%).<sup>10</sup>

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

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<sup>5</sup> See Table 1

<sup>6</sup> The DOJ defines relevant health insurance markets as local, a position that is uncontroversial. The local nature of healthcare 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 Prof. Leemore Dafny at <http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf>

Following the example of DOJ, the AMA has measured market concentration by using the Herfindahl-Hirschman Index (HHI) in metropolitan statistical areas within the state of California. 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.

<sup>7</sup> See Table 2

<sup>8</sup> See Table 3

<sup>9</sup> See Table 4

<sup>10</sup> See Table 5

### *Significant Barriers to Entry into California Health Insurance Markets*

The *prima facie* violation of the NAIC Competitive Standard and the Horizontal Merger Guidelines could hypothetically be rebutted by establishing the likelihood of timely and sufficient entry to alleviate concerns about the adverse competitive effects of the merger.<sup>11</sup> In the instant case, there is no reliable evidence establishing that entry would be timely, likely and sufficient. Indeed, the record is that successful entry into California health insurance markets has proven difficult.

#### Insurer Shares and Leadership Positions Have Been Durable in the Statewide and MSA Markets

AMA's analysis of data from HealthLeaders-Interstudy shows that in a statewide market and in the numerous large MSAs where the merger would be anticompetitive in commercial markets, the market shares and ranking of market leaders have been durable and little changed from 2010 thru 2013, the most recent timeframe for which we have data.

Against this background of durable large market shares possessed by the half dozen largest insurers in the state, Anthem claims a dizzying array and number of potential competitors including provider sponsored plans and a wide variety of insurers on the public marketplaces. But as the American Antitrust Institute correctly observes, the actual market record "cautions against the use of numbers of entrants into insurance markets to satisfy the well-established requirement that entry be sufficient i.e., that entrants can compete on a scale sufficient to restrain any post-merger exercise of market power".<sup>12</sup> Provider systems are unlikely to compete on a sufficient scale because they have the problem of securing cost-effective contracts from high quality rivals in their markets."<sup>13</sup> They also face a steep learning curve in entering health insurance markets and need to assemble technology and expertise to deal with actuarial, business, and health insurance regulatory issues.<sup>14</sup>

Nor have the health insurance marketplaces made successful entry easy. 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.<sup>15</sup>

According to the New York 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."<sup>16</sup> 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, enrollment, or

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<sup>11</sup> See Horizontal Merger Guidelines at 28.

<sup>12</sup> Thomas Greaney and Diana Moss , The American Antitrust Institute, correspondence to William Baer, Assistant Attorney General, US Department Of Justice Antitrust Division (January 11, 2016).

<sup>13</sup> Id.

<sup>14</sup> Id. See also Joseph Conn, *Health IT a Key Challenge for Provider-Owned Plans*, Modern Healthcare (June 27, 2015), <http://www.modernhealthcare.com/article/20150627/MAGAZINE/306279980>; see also Gunjan Khanna et al., McKinsey on Healthcare, *Provider-Led Health Plans: The Next Frontier—or the 1990s all over Again?*, McKinsey & Co. (Jan. 2015), <http://healthcare.mckinsey.com/provider-led-health-plans-next-frontier%E2%80%94or-1990s-all-over-agai>

<sup>15</sup> "Marco Rubio Quietly Undermines Affordable Care Act," The New York Times, December 10, 2015.

<sup>16</sup> "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>.

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.

Lost competition is likely to be permanent, and acquired health insurer market power would be durable, because barriers to entry prevent new entrants from restoring competitive pricing. 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.

Other 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.<sup>17</sup> 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.”<sup>18</sup> The Blues brand is perhaps the most powerful, as 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. A report commissioned by the Pennsylvania Insurance Department 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.<sup>19</sup>

### *The Loss of Potential Competition*

One of the most important implications of the barriers to entry that persist with the advent of the health insurance marketplaces is the need to preserve the potential competition that would be lost if an incumbent insurer is acquired. Thus, when one of the two largest commercial insurers in the state (Anthem) acquires the sixth largest (Cigna) the highly concentrated geographic markets

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<sup>17</sup> 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).

<sup>18</sup> 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>.

<sup>19</sup> LECG Inc., “Economic Analyses of the Competitive Impacts From The Proposed Consolidation of Highmark and IBC.” (September 10 2008) at 9.

where Anthem faces little competition are deprived of one of their most likely entrants, Cigna. 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.”<sup>20</sup>

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 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.<sup>21</sup>

## 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). We have concluded that on the sell side the merger is likely to result in higher premiums 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 and a reduction in 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 and/or quantity of services that physicians are able to offer patients.<sup>22</sup>

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<sup>20</sup> Dafny Senate Testimony, *supra* note 1, at 13.

<sup>21</sup> 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.

<sup>22</sup> 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](http://www.usdoj.gov/atr/cases/f213800/213815.htm).

### *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 resulting from the merger was associated with higher premiums.<sup>23</sup> 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% relative to a control group. These findings suggest that the merging parties exploited their resulting market power, to the detriment of consumers.<sup>24</sup>

Also, recent studies suggest premiums for employer sponsored fully insured plans are rising more quickly in areas where insurance market concentration is increasing.<sup>25</sup>

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.<sup>26</sup> 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%.<sup>27</sup> 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.<sup>28</sup>

There can be little doubt that an Anthem/Cigna merger would produce the higher premiums predicted by the relevant market concentrations and their merger-induced increase. Anthem has had no hesitation to increase premiums to levels that the California Department of Insurance (CDI) has found unjustified. For example, in April 2015 Anthem refused to lower an 8.7% premium increase imposed on consumers with individual grandfathered health insurance policies

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<sup>23</sup> Leemore Dafny et al, “Paying a Premium on your Premium? Consolidation in the US Health Insurance Industry,” *American Economic Review* 2012; 102: 1161-1185.

<sup>24</sup> 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.

<sup>25</sup> Dafny Senate Testimony, supra note 1, at 11.

<sup>26</sup> Id.

<sup>27</sup> 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.

<sup>28</sup> Dafny Senate Testimony, supra note 1, at 11.

affecting 170,000 people.<sup>29</sup> Similar increases over CDI objections occurred in 2012, 2013, and 2014.<sup>30</sup>

### Plan Quality

As Professor Dafny observes, “the competitive mechanisms linking diminished competition to higher prices operate similarly with respect to lower quality”.<sup>31</sup> For example, a study in the Medicare Advantage market found that more robust competition was associated with greater availability of prescription drug benefits.<sup>32</sup> Thus, the merger can be expected to adversely affect health insurance plan quality. This is illustrated by the aftermath of UnitedHealth Group’s acquisition of PacificCare in late 2005, one of the several health insurer mergers that DOJ has challenged and resolved through consent decrees that did not block the mergers.<sup>33</sup> Shortly after the transaction, the CMA saw a spike in complaints from physicians about the way PacifiCare was processing claims and contracts. CMA forwarded dozens of physician complaints to the DOI and requested the insurance regulator investigate. After conducting its own market conduct investigation, the DOI filed an administrative proceeding against United Healthcare, charging PacifiCare with violations that included: (1) failing to give providers notice of their appeal rights and members notice of their right to an independent medical review; (2) failing to timely pay or correctly pay claims as well as interest on late-paid claims; (3) failing to acknowledge receipt of claims; (4) failing to timely respond to provider disputes; (5) illegally closing claims files; and (6) sending untimely collection notices for overpayment. The CDI imposed penalties against UnitedHealthcare of more than \$173 million dollars for 900,000 violations of the California Insurance Code from 2005 to 2008.<sup>34</sup>

#### 1. Paying Bills Accurately and on Time

Service problems continue to plague the markets that a merged Anthem/Cigna would dominate. The CMA recently surveyed its members regarding the likely effects of the merger (CMA survey). 989 physicians completed the survey.<sup>35</sup> Respondents to the 2016 CMA survey complained of problems with prior authorizations. Comments included:

“Actually, they are becoming burdensome with pre-auths and low pay to the point where they are becoming a drag on viability”;

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<sup>29</sup> California Department of Insurance Press Release, April 22, 2016. Available at: <http://www.insurance.ca.gov/0400-news/0100-press-releases/2015/release044-15>.

<sup>30</sup> California Department of Insurance Press Release, October 23, 2014. Available at: <http://www.insurance.ca.gov/0400-news/0100-press-releases/2014/release113-14.cfm>; California Department of Insurance Press Release, April 2, 2013. Available at: <http://www.insurance.ca.gov/0400-news/0100-press-releases/2013/release029-13.cfm>; California Department of Insurance, Rate Filing No. HAO-2012-0177

<sup>31</sup> Dafny Senate Testimony, *supra*, note 1 at 11.

<sup>32</sup> Robert Town and Su Liu, "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* (2003): 719-736.

<sup>33</sup> *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](http://www.usdoj.gov/atr/cases/f213800/213815.htm)

<sup>34</sup> *CDI Imposes Record Penalties Against United*, Arch Apple Financial Services, (August 2, 2014), available at: <http://archapple.com/cdi-imposes-record-penalties-against-united/>

<sup>35</sup> This is the third largest number of responses that CMA has received to its surveys in recent memory.

“We wrestle with getting authorization for surgeries from these insurers. This leads to delay [in] care which can affect patient outcomes”;

“Multiple hoops to jump through to provide appropriate care”;

“Delays [in] authorizations for emergency care”;

“Anthem is appallingly bad at approving almost anything”;

“Delayed payments on uncontested bills is the most prevalent pervasive insurance tactic”;

“Unable to speak to people that speak English well enough to give the information I need to treat patients”;

“Very poor response time from insurers when phone calls are made by office. Wait time typically extends past 30 minutes per call”;

“Insane preapproval processes. Inability to speak to live person. Multiple denials of service.”

## 2. Network Adequacy

Insurers are already creating very narrow and restricted networks that force patients to go out-of-network to access care. A study by University of Pennsylvania researchers shows that 76 percent of health plans sold in California through Covered California have significantly limited networks. Specifically: 38% were considered "x-small," meaning they included 10% or less of providers in the rating area; 38% were considered "small," meaning they included 10% to 25% or less of providers in the rating area; 19% were considered "medium," meaning they included 25% to 40% of providers in the rating area; and 6% were considered "large," meaning they included 40% to 60% of providers in the rating area. No provider networks offered through the California exchange were considered by researchers to be "x-large," meaning they included 60% or more of providers in the rating area. In fact, some health plans have no in-network doctors in key-specialties.<sup>36</sup>

Of respondents to the CMA survey who are contracted with Anthem, 32% said that they had difficulty finding available in-network physicians who accepted new patients for referrals. 26% of respondents who are contracted with Cigna reported similar experiences. Moreover, 53% of respondents who are contracted with Anthem encountered formulary limitations which prevented a patient's optimal treatment. 42% of respondents contracted with Cigna reported similar experiences. Comments included:

“Some providers are more than 40 miles away”;

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<sup>36</sup> Stephen C. Dorner, et al., *Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act*, JAMA, October 27, 2015.

“No available colleagues”;

“Dead physicians listed as participating providers!” and

“No patients report being able to obtain timely appointments with primary care providers”.

An Anthem/Cigna merger threatens to further reduce access to care. 82% of physician practice decision-makers believe that the Anthem /Cigna merger *would very or somewhat likely* lead to narrower physician networks which will in turn reduce patient access to care.

The CDI clearly takes the issue of network adequacy and transparency very seriously given its actions over the last several years on provider networks and directories and its role on the NAIC workgroup that revised the NAIC network adequacy model bill. However, the CDI no doubt appreciates that network adequacy requirements/standards are no panacea for the weaker provider networks likely to result from the Anthem/Cigna merger. Generally speaking, the standards focus on notions of whether “enough” providers and facilities are included in the network. They address “adequacy” as a floor and not as a prescription for optimal physician and provider availability.

Moreover, in California, as elsewhere, state regulations do not address whether in-network providers are high-quality.<sup>37</sup> Consequently, health insurers can cherry pick physicians based on costs (not quality) in order to have the lowest cost patients. Therefore, rather than only relying on network adequacy requirements, regulators need to foster health insurer competition promising broader high quality networks responsive to patients’ access needs.

In sum, while regulation of provider networks and network products is a critical component of ensuring patient access to care, market competition/consumer pressures to maintain or improve the quality of products, including provider networks, is essential. Without competition among health insurers to offer comprehensive networks and accurate and accessible provider directories, patients will be choosing among low-quality products without the ability to vote with their feet.

## THE MERGER WOULD CREATE, ENHANCE OR ENTRENCH MONOPSONY POWER IN CALIFORNIA 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 (i.e. buyer power) in the purchase of physician services. 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.”<sup>38</sup> She further explained that the “textbook monopsony

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<sup>37</sup> Id.

<sup>38</sup> Dafny Senate Testimony, supra note 1, at 10.

scenario...pertains when there is a large buyer and fragmented suppliers.”<sup>39</sup> 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.<sup>40</sup> The result is a reduction in compensation leading to diminished physician service and quality of care that harms consumers.<sup>41</sup>

Indeed, even in markets where the merged health insurers might lack monopoly power to raise premiums for patients, the merged insurers would likely still have the power to force down physician compensation to anticompetitive levels. 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.<sup>42</sup> It is difficult to convince consumers (which in many cases are employers) to switch to different health insurers.<sup>43</sup> 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./PacificCare* 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 was straightforward: the reduction in compensation would lead to diminished service and quality of care, which harms consumers even though, given the lack of market power on the sell side, the direct premiums paid by subscribers do not increase.<sup>44</sup>

Moreover, the reduction in the number of health insurers would create health insurer oligopsonies 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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<sup>39</sup> Id.

<sup>40</sup> Carol K. Kane, PhD., American Medical Association Policy Research Perspectives: Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership, July 2015.

<sup>41</sup> 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/speeches/3924.wpd>.

<sup>42</sup> 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.

<sup>43</sup> 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)..

<sup>44</sup> 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/speeches/3924.wpd>.

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' reimbursements to providers—especially Medicaid—underpay physicians. Thus, even if a physician dropping a commercial health insurer could attract more Medicare and Medicaid patients, this strategy would be a losing proposition if one is to compete in the market, especially at a time when value-based payment models require practice investments.

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

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,<sup>45</sup> and the merger of UnitedHealth Group Inc. and Pacific Care in Tucson, Arizona and in Boulder, Colorado in 2005.<sup>46</sup>

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 Blue Shield of Michigan the ability to control physician payment rates in a manner that could harm the quality of healthcare delivered to consumers.”<sup>47</sup>

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.”<sup>48</sup> Health insurer monopsonists typically are also monopolists.<sup>49</sup> Facing little if any competition, they lack the incentive to pass along cost savings to consumers.<sup>50</sup>

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

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<sup>45</sup> *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>.

<sup>46</sup> *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](http://www.usdoj.gov/atr/cases/f213800/213815.htm).

<sup>47</sup> 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>.

<sup>48</sup> Dafny, supra note 1, at 9.

<sup>49</sup> Peter J. Hammer and William M. Sage, *Monopsony as an Agency and Regulatory Problem in Health Care*, 71 ANTITRUST L.J. 949 (2004).

<sup>50</sup> See Dafny at n.1 (“If past is prologue, insurance consolidation will tend to lead to lower payments to healthcare providers, but those lower payments will not be passed on to consumers. On the contrary, consumers can expect higher insurance premiums.”)

Highmark, Inc. and Independence Blue Cross. Based on an extensive record of nearly 50,000 pages of expert and other commentary,<sup>51</sup> 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.”<sup>52</sup> 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.<sup>53</sup>

### Results of CMA’s Survey

The CMA 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.<sup>54</sup> This is precisely the case in a merger of Anthem with Cigna. Seventy-one percent of physician respondents to the CMA survey felt they *had* to contract with Anthem in order to have a financially viable practice; and 47% felt that way with respect to Cigna. Sixty six percent and 45% of practice decision-makers who are contracted with Anthem and Cigna respectively, reported that contracts were “take it or leave it” offers.

While these percentages are indicative of monopsony power, the merger promises to make matters much worse. Eighty three percent of responding physicians said that the merger of Anthem and Cigna would make the process of contract negotiations less favorable for physicians.

Health insurer contracting practices also allow insurers to leverage their buyer power in commercial PPO plans, for example, to force physicians to participate in plans that they either do not want to serve or would prefer to serve on different terms. Forty-five percent of survey respondents report that Anthem negotiates one contract that covers all of the insurance plans they offer, rather than negotiate different physician contract terms for the different types of insurance

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<sup>51</sup> See [http://www.ins.state.pa.us/ins/lib/ins/whats\\_new/Excerpts\\_from\\_PA\\_Insurance\\_Dept\\_Expert\\_Reports.pdf](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.

<sup>52</sup> See Statement of Pennsylvania Insurance Commissioner Joel Ario on Highmark and IBC Consolidation (January 22, 2009).

<sup>53</sup> Id.

<sup>54</sup> 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.

plans offered (e.g. Medicare Advantage, commercial group health insurance, HMO-type products, PPO and indemnity products etc.). 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 - 57% 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 CMA survey also identified by very large percentages a number of anticompetitive effects likely to occur in the event of an Anthem/Cigna merger:

- An astonishing 89% 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;
- 82% 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:

- 31% would cut investments in practice infrastructure;
- 40% would cut or reduce staff salaries;
- 43% would have to spend less time with patients;
- 27% would cut quality initiatives or patient services.

These reductions in service levels and quality of care would cause immediate harm to consumers. In the long run, it is imperative to consider whether monopsony power enhanced in the merger would 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.<sup>55</sup> Recent projections by the Health Resources and Services

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<sup>55</sup> 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.

Administration similarly suggest a significant shortage of primary care physicians in the United States.<sup>56</sup>

According to the CMA survey, if Anthem/Cigna were to merge and the physicians did not continue to have a contract with the merged health plan, significant numbers of physicians would be driven from the market:

13% would retire from active practice;

15% would need to close their practice;

8% would move their practice to a more competitive reimbursement market.

#### *The Department Should Reject the Application to Merge to Protect Consumers*

Given that the proposed merger would result in countless highly concentrated commercial markets where the merged entity would either possess substantial market share or could exercise buyer power through coordinated interaction, it is critical for CDI to reject 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.”<sup>57</sup> This is a daunting test and reflects skepticism about efficiency defenses in merger cases also found in federal antitrust law.<sup>58</sup> (“The Supreme Court has never expressly approved an efficiencies defense to a [merger violation] claim....We remain skeptical about the efficiencies defense in general and about its scope in particular.”)<sup>59</sup> Under the Horizontal Merger Guidelines, Anthem’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 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:

<sup>56</sup> See Health Resources and Services Administration, Projecting the Supply and Demand for Primary Care Physicians through 2020 in Brief (November 2013).

<sup>57</sup> NAIC Model Act, Section 3.D (2)(d)

<sup>58</sup> See *St. Alphonsus Medical Center and Federal Trade Commission v. St. Luke’s*, 778 F.3d 775 (9<sup>th</sup> Cir, 2015).

<sup>59</sup> Id.

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 effect of a merger likely to be particularly substantial, extraordinarily great cognizable efficiencies would be necessary to prevent the merger from being anticompetitive.<sup>60</sup>

Anthem has met neither the NAIC Competitive Standard nor the Horizontal Merger Guidelines test for proving redeeming efficiencies. Anthem did not even identify, much less carry its burden of establishing, substantial economies of scale or economies in resource utilization. Anthem merely claims that the merger would allow the “combined companies” to “operate more efficiently to reduce operational costs...helping to create more affordable healthcare for consumers”.<sup>61</sup> How these efficiencies would emerge from the merger is not explained. As Health Access California, a statewide healthcare consumer advocacy coalition has noted: “Anthem and Cigna, the second and fifth largest insurers by revenue, are already humongous, scaled entities and it is unclear how they will get any more scale economies from getting even bigger”.<sup>62</sup> 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 the possibility of ceding market share.”<sup>63</sup> 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 commercial health insurers.<sup>64</sup>

And as Professor Dafny also 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.”<sup>65</sup> Indeed Anthem’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.

## DIVESTITURES WOULD BE UNWORKABLE AND INADEQUATE TO PROTECT CONSUMERS

Any remedy short of rejecting the merger application would not adequately protect consumers. Recent research has shown that divestitures often fail to restore competition in the marketplace.<sup>66</sup> Good examples of the inadequacy of the divestiture remedy in health insurance merger cases are

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<sup>60</sup> Horizontal Merger Guidelines, Section 10

<sup>61</sup> Prepared Statement of Joseph Swedish, President and CEO of Anthem before the United States Senate Committee on the Judiciary Subcommittee on Antitrust, Competition Policy, and Consumer Rights (September 22, 2015). Available at: <http://betterhealthcaretogether.com/content/uploads/2015/09/Swedish-Testimony-for-Senate-Judiciary-FINAL.pdf>

<sup>62</sup> Health Access California Letter to Dir., Department of Managed Health Care (March 9, 2016).

<sup>63</sup> Dafny Senate Testimony, *supra* note 1, at 16.

<sup>64</sup> Id.

<sup>65</sup> Id. at 16.

<sup>66</sup> John Kwoka, MERGERS, MERGER CONTROL, AND REMEDIES: A RETROSPECTIVE ANALYSIS OF U.S POLICY, MIT PRESS (2015).

illustrated by the retrospective studies of the United Health-Sierra and the Aetna-Prudential mergers showing that the consolidations resulted in significant premium increases notwithstanding both cases were resolved by consent decrees requiring divestitures.<sup>67</sup> Also, a divestiture would not protect against the loss of potential competition that occurs when one of the largest health insurers is eliminated. Moreover, divesture would likely be too disruptive to existing patient-physician relationships - a conclusion recently reached by the Florida Office of Insurance Regulation in rejecting Aetna/Humana divestitures in favor of conduct remedies.<sup>68</sup>

As a practical matter, the large number of markets adversely affected by the proposed merger, along with the barriers to entry to health insurance, makes unlikely that the CDI 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 large 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.

## CONCLUSION

Accordingly, AMA and CMA respectfully urge the CDI to reject Anthem's application to acquire Cigna. Rejection is needed to protect consumers from premium increases, lower plan quality and a reduction in the quantity and quality of physician services.

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<sup>67</sup> See *U.S. v. United Health Group and Sierra Health Services Inc.*, Civil No1:08 -cu-00322 (DDC2008); *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>.

<sup>68</sup> The Office of Insurance Regulation Consent Order in the matter of the Indirect Acquisition of Human Health Insurance Company of Florida, et al. by Aetna Inc. (February 15, 2016) at 8. (Consent Order)

**Tables to the Statement of the American Medical Association and the California Medical Association to the California Department of Insurance  
(March 29, 2016)**

**Table 1.** Four-Firm Concentration Ratio and Cigna's/Largest Insurers' Market shares in California, 2013

	<b>Mconame</b>	<b>Totalsh</b>	<b>Conratio</b>
1	Kaiser Permanente	30	80.8
2	WellPoint (Now Anthem)	29	80.8
3	BlueShield California	13	80.8
4	UnitedHealth Group	8	80.8
6 <sup>1</sup>	Cigna	5	.

**Table 2.** California MSAs where an Anthem-Cigna Merger Will Be Presumed Likely to Enhance Market Power

<b>Msaname</b>	<b>Tothhi</b>	<b>Posthhi</b>	<b>hhich</b>
Santa Cruz-Watsonville, CA	2934	3530	596
Santa Ana-Anaheim-Irvine, CA	1986	2514	528
Santa Barbara-Santa Maria, CA	3371	3849	478
Salinas, CA	4446	4888	442
Oxnard-Thousand Oaks-Ventura, CA	2471	2838	367
Los Angeles-Long Beach-Glendale, CA	2256	2575	319
Bakersfield, Ca	2664	2969	305
El Centro, CA	3125	3416	291
Modesto, CA	2453	2668	215

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<sup>1</sup> At the state level Cigna was the sixth largest in 2013

**Table 3.** Four-Firm Concentration Ratios and WellPoint's (Anthem) Cigna's Market Shares in California MSAs where an Anthem-Cigna Merger Will Be Presumed Likely to Enhance Market Power, 2013

<b>Msaname</b>		<b>Mconame</b>	<b>Totalsh</b>	<b>Conratio</b>
Santa Cruz-Watsonville, CA				
	1	WellPoint	48	83.9
	5	Cigna	6	.
Santa Ana-Anaheim-Irvine, CA				
	1	WellPoint	33	76.4
	6	Cigna	8	.
Santa Barbara-Santa Maria, CA				
	1	WellPoint	53	86.8
	6	Cigna	4	.
Salinas, CA				
	1	WellPoint	63	92.8
	5	Cigna	4	.
Oxnard-Thousand Oaks-Ventura, CA				
	1	WellPoint	43	81.8
	7	Cigna	4	.
Los Angeles-Long Beach-Glendale, CA				
	1	WellPoint	33	81.3
	7	Cigna	5	.
Bakersfield, CA				
	1	WellPoint	42	87.8
	5	Cigna	4	.
El Centro, CA				
	2	WellPoint	24	84.7
	3	Cigna	6	84.7
Modesto, CA				
	2	WellPoint	29	88.7
	5	Cigna	4	.

**Table 4.** Market Share Trends of Largest Insurers in California MSAs Where an Anthem-Cigna Merger will be Presumed Likely to Enhance Market Power, 2010-2013.<sup>2</sup> Wellpoint in the chart below is now Anthem.

Msa name		Mco13	Sh10	Sh11	Sh12	Sh13
Santa Cruz-Watsonville, CA	1	WellPoint	47	49	49	48
	2	BS of CA	19	19	20	21
	3	Health Net	10	10	9	8
	4	UnitedHealthcare	8	7	7	7
Santa Ana-Anaheim-Irvine, CA						
	1	WellPoint	33	32	33	33
	2	Kaiser	19	20	21	22
	3	BS of CA	13	12	12	11
Santa Barbara-Santa Maria, CA	4	Aetna	11	11	10	11
	1	WellPoint	45	51	51	53
	2	BS of CA	21	21	21	19
Salinas, Ca	3	Aetna	15	9	8	7
	4	Health Net	9	10	9	7
	1	WellPoint	68	65	64	63
Oxnard-Thousand Oaks-Ventura, CA	2	BS of CA	14	16	21	22
	3	Aetna	7	8	4	4
	4	UnitedHealthcare	5	5	4	4
Los Angeles-long Beach-Glendale, CA	1	WellPoint	31	31	32	33
	2	Kaiser	28	29	29	30
	3	BS of Ca	12	11	12	10
	4	UnitedHealthcare	9	10	9	9
Bakersfield, CA						
	1	WellPoint	45	43	42	42
	2	Kaiser	24	25	24	25
	3	BS of CA	13	15	15	15
El Centro, CA	4	UnitedHealthcare	7	7	6	6
	1	BS of CA	29	31	52	49
	2	WellPoint	60	58	29	24

<sup>2</sup> At the MSA level Cigna was usually fifth or sixth largest across MSAs in 2013

	3	Cigna	1	2	3	6
	4	UnitedHealthcare	5	4	6	5
Modesto, CA						
	1	Kaiser	34	36	34	34
	2	WellPoint	29	29	30	29
	3	BS of CA	17	16	19	19
	4	UnitedHealthcare	8	7	7	6

**Table 5.** Four-Firm Concentration Ratios and WellPoint's (Anthem) Cigna's Market Shares in California MSAs Where an Anthem-Cigna Merger Potentially Raises Significant Competitive Concerns and Often Warrants Scrutiny, 2013

Msaname	Mconame	Totalsh	Conratio
San Jose-Sunnyvale-Santa Clara, CA			
	2 WellPoint	22	79.8
	5 Cigna	8	.
San Diego-Carlsbad-San Marcos, CA			
	2 WellPoint	22	72.7
	6 Cigna	6	.
San Francisco-San Mateo-Redwood City, CA			
	2 WellPoint	21	81.2
	6 Cigna	6	.
Riverside-San Bernardino-Ontario, CA			
	2 WellPoint	23	79.3
	7 Cigna	5	.
Oakland-Fremont-Hayward, CA			
	2 WellPoint	18	84.5
	6 Cigna	5	.
Sacramento-Arden-Arcade-Roseville, CA			
	2 WellPoint	17	81.7
	7 Cigna	3	.