

**STATEMENT**

**of the**

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

**to the**

**Office of Insurance Regulation  
Florida Department of Financial Services**

**RE: Aetna Application for the Proposed Acquisition of Humana**

**December 17, 2015**

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

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

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

We have concluded that this merger will likely impair access, affordability, and innovation in the sell-side market for health insurance, and on the buy side, will deprive physicians of the ability to negotiate competitive health insurer contract terms. The result will be detrimental to consumers. "If past is prologue," notes Northwestern University Professor Leemore S. Dafny, PhD "insurance consolidation will tend to lead to lower payments to healthcare providers, but those lower payments will not be passed on to consumers. On the contrary, consumers can expect

higher insurance premiums.”<sup>1</sup> Therefore, Aetna has not carried *its* “burden of proof” that the effect of the acquisition would *not* substantially lessen competition in the line of insurance for which the specialty insurer is licensed or certified in the state or would not tend to create a monopoly therein.”<sup>2</sup> Accordingly, Aetna’s application to acquire Humana should be denied or, in the alternative, the Office of Insurance Regulation (OIR) should continue the hearing giving interested parties a meaningful opportunity to be heard.

#### PROCEDURAL BACKGROUND AND REQUEST THAT HEARING REMAIN OPEN

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

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

Both the American Medical Association and the American Hospital Association have urged federal antitrust regulators to halt the planned merger, saying it would reduce competition and limit patient’s access to quality, affordable healthcare.

But at the capital on Monday, no critics appeared to oppose the merger, which would impact about 2.4 million people spanning four licensed Humana insurance companies in Florida.

Instead, a panel of the office of insurance regulation... heard testimony from a handful of Aetna and Humana executives and witnesses for the companies.<sup>3</sup>

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

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<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.

<sup>2</sup> Section 628.4615 (8) and Section 628.465 (8) (j), Florida statutes.

<sup>3</sup> See *No critics show up for hearing on proposed Aetna-Humana merger*, available at <http://politi.co/1IQYQLq>

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

## LEGAL STANDARD

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

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

### *Commercial Health Insurance*

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

### Merger Violates NAIC Competitive Standard

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

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

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<sup>4</sup> Section 628.4615 (8) and Section 628.465 (8) (j), Florida Statutes.

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

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

### Merger Violates Federal Antitrust Merger Enforcement Standards

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

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

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

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

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

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

#### *Florida Commercial Enrollment—Individually Underwritten Plans*

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

#### Merger Violates NAIC Competitive Standard

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

#### Merger Violates Federal Antitrust Merger Enforcement Standards

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

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

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

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<sup>7</sup> U.S. Department of Transportation Bureau of Transportation Statistics, “Airline Domestic Market Share July 2014-June 2015,” available at <http://www.transstats.bts.gov/>.

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

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

### *Medicare Advantage*

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

### Merger Violates NAIC Competitive Standard

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

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

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

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

<sup>10</sup> For a discussion of the dismal condition of competition in Medicare Advantage see: B. Biles, G. Casillas, and S. Guterman, *Competition Among Medicare's Private Health Plans: Does It Really Exist?* The Commonwealth Fund, August 2015; Gretchen Jacobson, Anthony Damico, and Marsha Gold, Kaiser Family Foundation Issue Brief, *Medicare Advantage 2015 Spotlight: Enrollment Market Update*, (June 30, 2015), Figure 1, available at: <http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/>.

<sup>11</sup> See McCarthy Table 6.

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

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

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

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

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<sup>12</sup> See also Bertolini, "Examining Consolidation in the Health Insurance Industry and its Impact on Consumers," Testimony before the Senate Committee on the Judiciary, September 22, 2015, at 5.

<sup>13</sup> See Horizontal Merger Guidelines, Section 4.

<sup>14</sup> See *U.S. v. UnitedHealth Group and Sierra Health Services Inc.*, Civil No1:08 –cu-00322 (DDC2008); *United States v. Humana*, No. 12-cv-00464 (D.D.C. Mar. 27, 2012), available at: [www.justice.gov/atr/cases/f281600/281618.pdf](http://www.justice.gov/atr/cases/f281600/281618.pdf).

<sup>15</sup> See competitive impact statement, *United States v. UnitedHealth*, supra, at 4-5.

<sup>16</sup> See *U.S. v. UnitedHealth Group and Sierra Health Services Inc.*, Civil No1:08 –cu-00322 (DDC2008) (the DOJ alleged that Medicare Advantage is a distinct market separate from the Medicare market and obtained a consent decree requiring the

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

#### *BARRIERS TO ENTRY AND THE NEED TO PRESERVE POTENTIAL COMPETITION*

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

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

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

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

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

<sup>18</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

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>19</sup>

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

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

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

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

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

<sup>19</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>20</sup> *Id.* at 7.

<sup>21</sup> LECG Inc., “Economic Analyses of the Competitive Impacts From The Proposed Consolidation of Highmark and IBC.” September 10 2008, Page 9.

<sup>22</sup> “Marco Rubio Quietly Undermines Affordable Care Act,” the New York Times, December 10, 2015.

<sup>23</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>.

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

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

### *The Loss of Potential Competition*

One of the most important implications of the barriers to entry that persist with the advent of the marketplaces is the need to preserve the potential competition that would be lost if an incumbent insurer is acquired. Thus, when the largest insurer of Medicare Advantage (Humana) is acquired by the fourth-largest (Aetna) to form the largest Medicare Advantage insurer in Florida, the highly concentrated geographic markets where Humana faces little competition are deprived of their most likely entrant, Aetna. The foreclosure of this future market role serves to lessen competition. Professor Dafny expressed concern about this loss of potential competition in her Senate testimony: “[C]onsolidation even in non-overlapping markets reduces the number of potential entrants who might attempt to overcome price-increasing (or quality-reducing) consolidation in markets where they do not currently operate.”<sup>26</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

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<sup>24</sup> *Supra*, note 22

<sup>25</sup> This \$1.5 billion Startup is Making Health Insurance Suck Less, *Wired*, March, 20, 2015, available at <http://www.wired.com/2015/04/oscar-funding/>.

<sup>26</sup> Dafny, *supra* note 1, at 13.

the exchanges by entering a number of new states. [Citation omitted]. Thus reducing the array of formidable potential entrants into exchange markets from the “Big 5” to be “Remaining 3” will undermine the cost containment effects of competition in exchange markets. The lessons of oligopoly are pertinent here: consolidation that would pare the insurance sector down to less than a handful of players is likely to chill the enthusiasm for venturing into a neighbor’s market or engaging in risky innovation. One need look no further than the airline industry for a cautionary tale.<sup>27</sup>

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

Just as the merger would enhance market power on the selling side of the market, it would also enhance monopsony or buyer’s power in the purchase of inputs such as physician services, eviscerating physicians’ ability to contract with alternative insurers in the face of unfavorable contract terms and ultimately inefficiently reducing the quality or quantity of services that physicians are able to offer patients. As Professor Dafny explained in her recent Senate testimony on this merger: “Monopsony is the mirror image of monopoly; lower input prices are achieved by reducing the quantity or quality of services below the level that is socially optimal.”<sup>28</sup> She further explained that the “textbook monopsony scenario...pertains when there is a large buyer and fragmented suppliers.”<sup>29</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>30</sup>

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

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

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<sup>27</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>28</sup> Dafny, *supra* note 1, at 10.

<sup>29</sup> *Id.*

<sup>30</sup> Carol K. Kane, PhD., American Medical Association Policy Research Perspectives: Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership, July 2015.

<sup>31</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/spceches/3924.wpd>.

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

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

## THE PROPOSED MEGAMERGER IS LIKELY TO HARM CONSUMERS

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

### *Likely Detrimental Effects for Consumers in the Health Insurance Marketplace*

#### Price Increases

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

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

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<sup>32</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).

<sup>33</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.

relative to a control group. These findings suggest that the merging parties exploited their resulting market power, to the detriment of consumers.<sup>34</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>35</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>36</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>37</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>38</sup>

### Plan Quality

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

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

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<sup>34</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>35</sup> Dafny, supra note 1, at 11.

<sup>36</sup> Dafny et al., supra note 1, at 11.

<sup>37</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>38</sup> Dafny supra note 1, at 11.

<sup>39</sup> Dafny supra, note 1 at 11.

<sup>40</sup> Robert Town and Su Liu, "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* (2003): 719-736.

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

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

The DOJ has successfully challenged two health insurer mergers (half of all cases brought against health insurer mergers) based in part on DOJ claims that the mergers would have anticompetitive effects in the purchase of physician services. These challenges occurred in the merger of Aetna and Prudential in Texas in 1999,<sup>41</sup> and the merger of UnitedHealth Group Inc. and Pacific Care in Tucson, Arizona and in Boulder, Colorado in 2005.<sup>42</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 Michigan the ability to control physician payment rates in a manner that could harm the quality of healthcare delivered to consumers.”<sup>43</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>44</sup> Health insurer monopsonists typically are also monopolists.<sup>45</sup> 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,<sup>46</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

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<sup>41</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/sf2600/2648.pdf>.

<sup>42</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>43</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>44</sup> Dafny, supra note 1, at 9.

<sup>45</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>46</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.

provider networks for consumers who depend on these networks for access to quality healthcare.”<sup>47</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>48</sup>

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

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

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

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<sup>47</sup> See Statement of Pennsylvania Insurance Commissioner Joel Ario on Highmark and IBC Consolidation (January 22, 2009).

<sup>48</sup> Id.

<sup>49</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.

<sup>50</sup> See Health Resources and Services Administration, *Projecting the Supply and Demand for Primary Care Physicians through 2020 in Brief* (November 2013).

<sup>51</sup> Deloitte 2013 Survey of U.S. Physicians: Physician perspectives about health care reform in the future of the medical profession.

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

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

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

*OIR Should Reject the Application to Merge to Protect Consumers*

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

**MERGER EFFICIENCY CLAIMS ARE UNSUPPORTED AND SPECULATIVE**

The NAIC Competitive Standard provides that a merger may be approved if “the acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or the acquisition will substantially increase the availability of insurance, and the public benefits of the increase exceed the public benefits which would arise from not lessening competition.” This is a daunting test and reflects skepticism about efficiency defenses in merger cases also found in federal antitrust law.<sup>53</sup> (“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.”)<sup>54</sup> Under the Horizontal Merger Guidelines, Aetna’s claimed efficiencies are not to be credited unless they are “merger specific”—likely to be accomplished with the proposed merger and unlikely to be achieved in the absence of the merger. Also, claimed efficiencies must be “verifiable” and “cognizable,” meaning parties asserting the existence of efficiencies bear the burden of substantiating them with evidence relating to their

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<sup>52</sup> Id.

<sup>53</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>54</sup> Id.

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

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

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

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

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

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

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<sup>55</sup> Horizontal Merger Guidelines, Section 10

<sup>56</sup> Id. at 16.

<sup>57</sup> Dafny, supra note 1, at 16.

other sources, such as provider systems...and non-national payers,” according to Professor Dafny, not commercial health insurers.<sup>58</sup>

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

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

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

## CONCLUSION

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

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

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

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<sup>58</sup> Id.