New Hampshire
MEDICAL SOCIETY
ADVOCATING FOR PHYSICIANS & PUBLIC HEALTH SINCE 1791

NH INSURANCE DEPARTMENT
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January 7, 2016

COPY

The Honorable Maggie Hassan
State House
107 North Main Street
Concord, New Hampshire 03301

Dear Governor Hassan,

I am writing to express the Medical Society's concerns with the proposed acquisition of Cigna by Anthem, both of which operate in the State of New Hampshire and provide fully insured and self-funded health insurance products to individuals, as well as small and large businesses. While this potential transaction will be reviewed by the U.S. Department of Justice, we believe it essential that the proposed merger be given vigorous scrutiny by the New Hampshire Department of Justice and the New Hampshire Insurance Department. This transaction threatens potential harm to consumers, businesses, and health care providers in the Granite State.

As one of the states with highly concentrated health insurance markets, Anthem's acquisition of Cigna would greatly compound that concentration. As a result of the merger, Anthem could have more than a 60 percent share of the commercial health insurance market – a level that is presumptively anticompetitive. To remedy this situation, Cigna would apparently need to divest as many as 91 percent of its some 170,000 covered lives to an acceptable acquirer. Finding a qualified acquirer that can adequately serve so many of our consumers' needs and remain viable in the market is a huge and perhaps insurmountable task made more difficult by the high barriers to entry into the health insurance market. It is unclear that a willing and viable alternative exists in the Northern New England marketplace for such a substantial divestiture.

Enclosed, please find a recent letter from the American Medical Association to the U.S. Department of Justice concerning this proposed merger. While there is clearly a federal role in reviewing the proposed acquisition of Cigna by Anthem, we urge state regulators to take an active role to protect consumers, businesses and health care providers.

Sincerely,

James G. Potter
Executive Vice President

cc: Joseph Foster, Attorney General, Department of Justice
Roger Sevigny, Commissioner, Insurance Department ✓
Jeffrey Meyers, Acting Commissioner, Department of Health and Human Services

AMA
AMERICAN MEDICAL ASSOCIATION

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COPY

November 11, 2015

The Honorable William Baer
Assistant Attorney General
United States Department of Justice
Antitrust Division
950 Pennsylvania Avenue, NW
Washington, DC 20530

Dear Assistant Attorney General Baer:

The American Medical Association (AMA) greatly appreciates the opportunity to provide our comments to the Antitrust Division as it engages in the vital work of investigating Aetna's proposed acquisition of Humana and Anthem's proposed acquisition of Cigna. We believe that high insurance market concentration is an important issue of public policy because the anticompetitive effects of insurers' exercise of market power pose a substantial risk of harm to consumers. Our analyses of the proposed health insurance mergers reveal significant concerns with respect to the impact on consumers in terms of health care access, quality, and affordability.

SUMMARY

- The proposed mergers are occurring in markets where there has already been a near total collapse of competition. Under the U.S. Department of Justice/Federal Trade Commission Merger Guidelines, the proposed mergers are presumed to enhance market power in a vast number of commercial and Medicare Advantage markets. Because of persisting high barriers to entry in health insurance markets, the lost competition through these proposed mergers would likely be permanent and the acquired health insurer market power would be durable.

- A growing body of peer-reviewed literature suggests that greater health insurer consolidation leads to price increases, as opposed to greater efficiency or lower health care costs. The proposed mergers can be expected to lead to a reduction in health plan quality. Insurers are already creating very narrow and restricted networks that force patients to go out of network to access care. The mergers 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.

- Health insurer monopsony, or buyer power, acquired through the proposed mergers would, as the Department of Justice has found in earlier cases, likely degrade the quality and reduce the quantity of physician services. Consumers do best when there is a competitive market for purchasing physician services. When mergers result in monopsony power and physicians are reimbursed at below competitive levels, consumers may be harmed in a variety of ways. Physicians may be forced to spend less time with patients to meet practice expenses. They also may be hindered in their ability to invest in new equipment, technology, training, staff, and other practice infrastructure that could improve the access to and quality of patient care and could enable physicians to successfully transition into new value-based payment and delivery models. Furthermore, in the long run health insurer exercise of monopsony power may motivate physicians to retire early or seek opportunities outside of medicine that are more rewarding. This would exacerbate an already significant shortage of primary care physicians in the United States.

- There is no evidence supporting the insurer's claim that the proposed mergers would lead to greater efficiencies and innovative payment and care management programs. There is also no economic evidence that consumers benefit when health insurers merge to respond to hospital consolidation by acquiring countervailing power.

- Fostering competition, not consolidation, benefits American consumers through lower prices, better quality, and greater choice.

- Accordingly, the AMA urges the Department of Justice to block the proposed mergers.

THE FOUNDATION FOR AMA'S CONCLUSIONS

The AMA has participated in Congressional hearings on Anthem's proposed acquisition of Cigna and Aetna's proposed acquisition of Humana. In the course of these hearings, the AMA has analyzed the likely competitive effects of these mergers both in the sell-side market for insurance and the buy-side market for physician services. The AMA has considered data compiled annually by the AMA on competition in health insurance, recent studies on the effects of health insurance mergers, the testimony of experts called by House and Senate committees, and the written submissions and testimony of the merging parties.

The AMA has reviewed this matter from the long-standing AMA 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.

The AMA has concluded that these mergers are likely to 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 in markets around the country. The result will be detrimental to consumers. "If past is prologue," notes Leemore Dafny, Ph.D., "insurance consolidation will tend to lead to lower payments to healthcare providers, but those lower payments will not be passed

on to consumers. On the contrary, consumers can expect higher insurance premiums."[1] Moreover, monopsony power acquired through the mergers would enable the health insurers to control physician payment rates in a manner that could harm the quality of healthcare delivered to consumers.[2] Therefore, the AMA opposes the proposed mergers.

MARKET SHARES AND MARKET CONCENTRATION

Competition is likely to be greatest when there are many sellers, none of which has any significant market share. Unfortunately, health insurance markets are mostly highly concentrated, meaning that typically there are few sellers and they possess significant market shares. The AMA has determined that the proposed mergers are likely to create, enhance, or entrench market power in numerous markets.

Commercial Health Insurance

For the past 14 years, the AMA has conducted the most in-depth annual study of commercial health insurance markets in the country. From 2001 to 2010, the study was based on the 1997 U.S. Department of Justice (DOJ) and Federal Trade Commission (FTC) Horizontal Merger Guidelines. Beginning with the 2011 Update, the AMA's study utilizes the 2010 iteration of the Merger Guidelines to classify markets based on whether mergers announced in those markets would raise anticompetitive concerns.[3] The AMA's most recently published study, *Competition in Health Insurance: A Comprehensive Study of US Markets* (2015 update) is intended to help researchers, policymakers, and federal and state regulators identify areas of the country where consolidation among health insurers may have harmful effects on consumers, on providers of care, and on the economy. It presents health insurance market shares and concentration levels in states and metropolitan statistical areas (MSA). The AMA's study shows that there has been a near total collapse of competition in commercial, combined HMO + PPO + POS markets. In seven out of 10 metropolitan areas, these markets are highly concentrated. Moreover, 38 percent of metropolitan areas had a single health insurer with a commercial market share of 50 percent or more. Fourteen states have a single health insurer with at least a 50 percent share of the commercial health insurance market.

Medicare Advantage

The 2015 Update to its Competition in Health Insurance study does not cover the Medicare Advantage markets, which is where the merger of Humana and Aetna will be most acutely felt. However, competitive conditions in Medicare Advantage markets appear to be even more troubling than in the commercial health insurance market studied by the AMA. According to a Commonwealth Fund study published last month, 97 percent of Medicare Advantage markets (evaluated geographically at the county level) are highly concentrated and therefore characterized by a lack of competition.[4]

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[1] See Dafny, "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?" Testimony before the Senate Committee on the Judiciary, September 22, 2015, at 10.

[2] 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

[3] U.S. Dep't of Justice and Fed. Trade Comm'n, Horizontal Merger Guidelines (Aug. 19, 2010), *available at*: https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf.

[4] B. Biles, G. Casillas, and S. Guterman, *Competition Among Medicare's Private Health Plans: Does It Really Exist?* The Commonwealth Fund, August 2015.

Aetna has argued that insurer share of Medicare Advantage is of no antitrust relevance 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.[5] This argument glosses over the many critically important differences between Medicare Advantage and traditional Medicare that explain why Medicare is not an adequate substitute for Medicare Advantage, such that the proposed mergers should be evaluated for their effects in the Medicare Advantage market separately. Medicare Advantage plans offer substantially richer benefits at lower costs than traditional Medicare.[6] 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.[7] 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.[8]

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

The Anthem-Cigna Merger

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 Anthem-Cigna merger. The AMA analysis shows the proposed Anthem-Cigna merger would be presumed likely, under the Merger Guidelines, to enhance market power in 85 commercial (combined HMO + PPO + POS) MSA markets. The AMA also considered the effect of the merger using states as a geographic market. The AMA found that within 10 of the 14 states (NH, IN, CT, ME, VA, GA, CO, MO, NV, and KY) in which Anthem is licensed to provide commercial coverage, the merger is likely to enhance market power. In the remaining four states (OH, CA, NY, and WI), the merger would potentially raise significant competitive concerns and warrant scrutiny under the Merger Guidelines.

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[5] 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.

[6] *See U.S. v. United Health 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).

[7] See competitive impact statement, *United States v. United health*, supra, at 4-5.

[8] *See U.S. v. United Health Group and Sierra Health Services Inc.*, Civil No1:08 –cu-00322 (DDC2008) (the DOJ alleged that MA is a distinct market separate from the Medicare market and obtained a consent decree requiring the divestiture of United's MA 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.

Confirming the grave structural harm found by the AMA in numerous commercial health insurance markets is a slightly different market study commissioned by the American Hospital Association (AHA). That study examined MSAs *and rural counties* as the relevant geographic markets. The AHA reports that the transaction threatens to reduce competition in the sale of commercial health insurance in at least 817 relevant geographic markets. In 600 of these markets the transaction would be presumed to be likely to enhance market power under the Merger Guidelines. In another 217 markets the AHA found that under the Merger Guidelines the merger would potentially raise significant competitive concerns.

The health insurers have asked regulators to assume, without evidence, that health insurance markets are competitive "due to numerous competitors" and "other market realities." For example, in Anthem's Competitive Impact Analysis that was part of its September 22, 2015, Connecticut Insurance Department application, the insurer contends:

> Due to the numerous competitors, changing health care dynamics, new entrants, public and private exchanges, new distribution channels and business models, increasing transparency, sophisticated purchasers, and other marketplace realities, Anthem believes that Anthem's acquisition of control of CIGNA will not substantially lessen competition in insurance or tend to create a monopoly in the State of Connecticut with respect to any line of business.

Notably, the Anthem "competitive analysis" provides no evidence in support of its contention that the health insurance industry in Connecticut is highly competitive and becoming more competitive. Anthem provides no data to support this opinion—no reporting of market shares, Herfindahl-Hirschman Indices (HHI), or changes in either as a result of the proposed merger. Anthem's only mention of market shares is the motivation for why it prepared the analysis in the first place: In the commercial health insurance lines of business (as well as vision and dental standalone lines of business), the Anthem-Cigna merger does not meet the pre-acquisition notification exemption standard set forth in the Connecticut General Statutes. Instead, Anthem simply lists competitors to Anthem and Cigna in the individual, small group, large group, standalone vision and standalone dental lines of business as its primary evidence of competition, and argues that the growing use of public and private exchanges, benefit administration platforms, and other technology improvements will further ensure that "competition within the health insurance market will remain vigorous and vibrant."

In contrast, a review of data from the AMA's 2015 Update to its Competition in Health Insurance study, the Connecticut Insurance Department, and the Government Accountability Office's December 2014 report on private health insurance concentration, show that Connecticut's health insurance market is already highly concentrated. Using data from its 2015 Update, a special analysis conducted by the AMA in September 2015 shows that the proposed merger between Anthem and Cigna would exceed federal antitrust guidelines in Connecticut (i.e., increase in HHI of 1,311 points for a post-merger total HHI of 3,855) and in six of its metropolitan areas (MSAs).

The Aetna-Humana Merger

Turning to the proposed merger of Humana and Aetna, that merger would combine one of the two largest insurers of Medicare Advantage (Humana) with the fourth largest (Aetna) to form the largest Medicare

Advantage insurer in the country.[9] This would further concentrate a market that is already "highly concentrated among a small number of firms."[10] As in the case of the Anthem/Cigna merger, the Aetna/Humana merger would have a substantial impact on a staggering number of markets. According to a market study commissioned by the AHA, more than 1000 markets (defined geographically as counties) would become highly concentrated. Under the Merger Guidelines, the merger is presumed to be likely to enhance market power in 924 counties and potentially raises significant competitive concerns in another 159 counties.

In addition to presumptively enhancing market power in Medicare Advantage markets, the Aetna/Humana merger will exacerbate the near total collapse of competition in commercial markets. AMA analysis shows that the merger would be presumed to enhance market power in the commercial markets of health insurance in 15 MSAs within seven states (FL, GA, IL, KY, OH, TX, and UT).

Competition for Contracts in National Market

There may also be a national market in which the health insurers compete or potentially compete for the contracts of large national employers. In that market there are only five national health insurance companies remaining today: Anthem, Cigna, Aetna, Humana and United Healthcare. The proposed Anthem/Cigna and Aetna/Humana mergers would pare the number of national players to three.

THE HEALTH INSURER MERGERS CREATE, ENHANCE, OR ENTRENCH MONOPSONY POWER IN MARKETS FOR THE PURCHASE OF PHYSICIAN SERVICES

Just as the health insurer mergers would enhance market power on the selling side of the market, the mergers also would 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 Senate testimony on these mergers, "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."[11] When as here firms can also exercise seller power, the reduced prices for inputs (physician services) cause higher, not lower, output prices (health insurance premiums). See *Telecor Communications, Inc. v. S.W. Bell Tel. Co.*, 305 F.3d 1124, 1136 (10th Cir. 2002) (explaining that monopsony affects consumers because "there is a dead-weight loss associated with imposition of monopsony pricing restraints," and "[s]ome producers will either produce less or cease production altogether, resulting in less-than-optimal output of the product or service, and over the long run higher consumer prices, reduced product quality, or substitution of less efficient alternative products"). In addition to producing higher insurance premiums and a reduction in the quantity and quality of physician services, the lower than competitive physician reimbursements will deny physicians the rates necessary to support delivery reforms associated with value-based care, the cost of which the physicians—not the health insurers—must bear.

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[9] 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/.

[10] Id. at 13.

[11] Dafny at 10

In concluding that the mergers would enhance monopsony power, the AMA has followed the analytical techniques supplied by the Merger Guidelines, which require a definition of both a product market and geographic market.

The relevant product market is physician services. Insurers purchase many inputs, including physician services. There are no adequate substitutes for physician services, due to training and expertise.[12] Moreover, physicians are confined to supplying services within their training and licensure and cannot do something else in response to a decrease in compensation.[13]

The geographic markets in which health insurers secure services from physicians roughly coincide with the localized geographic markets in which the insurer sells its services to consumers.[14] Health insurers must obtain physician coverage in each locale where they sell insurance. Physicians are not mobile—they invest and develop their practices locally. Accordingly, the DOJ has embraced the notion of a localized market in which health insurers purchase physician services.[15] As the DOJ explained in the Aetna/Prudential complaint:

> The patient preferences that define a localized geographic market for the sale of HMO and HMO-POS products also define a localized geographic market for physician services. Moreover, for an established physician who has invested time and expense in building a practice, the costs associated with moving his or her practice to a new geographic market are considerable, including paying for new office space and equipment and building new relationships with hospitals, other physicians, employees, and patients in the area.[16]

A loss of competition on the buy side can occur within the localized geographic markets when the merging health insurers hold contracts with a significant number of providers who are financially dependent on contracting with the merging health plans and could not readily replace that business by dealing with other payers.[17]

According to Professor Dafny, the "textbook monopsony scenario…pertains when there is a large buyer and fragmented suppliers."[18] 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.[19] Moreover, if physicians were to refuse the terms of any health insurer, they would likely suffer an irretrievable loss of revenue. That is because medical services can neither be stored nor exported. Consequently, a physician's ability to consider realistically terminating a relationship with the merged insurers because of

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[12] *See U.S. v. United Health Group and Sierra Health Services Inc.*, Civil No1: 08 –cu-00322 (DDC2008), affidavit of Professor David Dranove, PhD (February 25, 2008).

[13] Id.

[14] See e.g., Capps, C. Buyer Power in Health Plan Mergers, J Comp Law and Econ. 2009; 6:375-391

[15] See e.g. *U.S. v. Aetna Inc.*, Complaint, No. 3-99CV 1398-H, ¶ 20 (June 21, 1999), available at http://www.justice.gov/file/483516/download, (alleging that the relevant geographic markets were the MSAs in and around Houston and Dallas, Texas).

[16] Id. at ¶¶ 19-20.

[17] Christine White, Sarahlisa Brau, and David Marx, Antitrust and Healthcare: A Comprehensive Guide, at 163 (2013); see also 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.

[18] 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.

[19] Carol K. Kane, PhD, American Medical Association Policy Research Perspectives: Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership, July 2015.

low payment rates depends on that physician's ability to make up lost business by immediately switching to an alternative health insurer. However, it is difficult to convince consumers (which in many cases are employers) to switch to different health insurers.[20] Also, switching health insurers is a very difficult decision for physicians because it impacts their patients and disrupts their practice. The physician-patient 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.

Given the nature of physician practices, even in markets where the merged health insurers lack monopoly or market power to raise premiums for patients, the insurers 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.[21]

Moreover, the reductions in the number of health insurers can create health insurer oligopolies that, through coordinated interaction, can exercise buyer power. Indeed the setting of payment rates paid to physicians is highly susceptible to the exercise of monopsony power through coordinated interaction by health insurance companies. The payment rates offered to large numbers of physicians by single health insurers are fairly uniform, and health insurance companies have a strong incentive to follow a price leader when it comes to payment rates.

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. Consequently, health insurers can exercise monopsony power in the commercial health insurance market.[22]

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[20] 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)..

[21] *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.

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

Given the high market concentration levels and large commercial and MA market shares that would result from the proposed mergers in the numerous MSAs and counties identified by the AMA and AHA, the proposed Mergers would create, enhance, or entrench monopsony power.

BARRIERS TO ENTRY AND THE NEED TO PRESERVE POTENTIAL COMPETITION

The market share and concentration data do not overstate the mergers' future competitive significance in health insurance and physician markets. This is not a case where new market entry could defeat an exercise of monopoly or monopsony power. Instead, lost competition through a merger of health insurers is likely to be permanent and acquired health insurer market power would be durable because barriers to entry prevent the higher profits often associated with concentrated markets from allowing new entrants to restore competitive pricing. These barriers include state regulatory requirements; the need for sufficient business to permit the spreading of risk; and contending with established insurance companies that have built long-term relationships with employers and other consumers.[23] 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."[24]

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.[25]

The presence of significant entry barriers in health insurance markets was demonstrated in the 2008 hearings before the Pennsylvania Insurance Department on the competition ramifications of the proposed merger between Highmark Inc. and Independence Blue Cross. Substantial evidence was introduced in those hearings, showing that replicating the Blues' extensive provider networks constituted a major barrier to entry. The evidence further demonstrated that there has been very little in the way of new entry that might compete with the dominant Blues Plans in the Pennsylvania health insurance markets. In a report commissioned by the Pennsylvania Insurance Department, LECG concluded that it was unlikely that any competitor would be able to step into the market after a Highmark/IBC merger:

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

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[23] *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).

[24] 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.

[25] Id. at 7.

> unlikely that other health insurance firms will be able to step in and replace the loss in competition.[26]

The merging health insurers have argued that times have changed and the health insurance marketplaces have made entry easy. The facts however do not bear out that claim. Recent state developments only highlight the barrier to entry problem. The *New York Times* recently reported "tough going for health co-ops" created under the Affordable Care Act (ACA) to inject competition into health insurance markets.[27] 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." According to the *Washington Post* of October 10, nearly half of the 23 ACA insurance co-ops, subsidized by millions of dollars in government loans, have been told by federal regulators that their finances, enrollment, or business model need to "shape up." One co-op has folded and four others are preparing to close in late December, including top-tier co-ops that federal officials had regarded as best poised to succeed.[28] More closure announcements are expected.[29] The quick death of these co-ops illustrate that even with heavy federal subsidies, health insurance is a tough business to enter.

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 the CEOs of Aetna and Anthem as an example of successful entry in their testimony before the Senate Judiciary Committee. (Anthem's CEO referred to Oscar as "emblematic of the changing face of the competitive landscape in the insurance industry.") 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."[30] In any event, the insurers' bold claim of new entry is not evidence and their descriptions of new entry opportunities are as consistent with the insurance markets experiencing net exit as with their assertions of net entry.

The Loss of Potential Competition

One of the most important implications of the barriers to entry that persist with the advent of the exchanges 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 insurers of Medicare Advantage (Humana) is acquired by the fourth-largest (Aetna) to form the largest Medicare Advantage insurer in the country, 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."[31]

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

[27] "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

[28] "Financial health shaky at many Obamacare insurance co-ops," The Washington Post, October 10, 2015, available at https://www.washingtonpost.com/national/health-science/financial-health-shaky-at-many-obamacare-insurance-co-ops/2015/10/08/2ab8f3ec-6c66-11e5-9bfe-e59f5e244f92_story.html?postshare=3211444658813888

[29] Id.

[30] 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/.

[31] Dafny, supra note 15, at 13.

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.[32]

THE PROPOSED MEGAMERGERS ARE LIKELY TO HARM CONSUMERS

The AMA has evaluated the potential effects of the proposed megamergers 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).[33] The AMA has concluded that on the sell side the mergers are 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 mergers could enable the merged entities 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.[34] 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,

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[32] 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.

[33] *U.S. v. Aetna Inc.*, supra note 12, at ¶¶ 17-18; *United States v. United Health Group Inc.* No. 1:05CV02436 (D.D.C., Dec. 20, 2005) (complaint), available at www.usdoj.gov/atr/cases/f213800/213815.htm.

[34] Leemore Dafny et al, "Paying a Premium on your Premium? Consolidation in the US health insurance industry," *American Economic Review* 2012; 102: 1161-1185.

premiums in Nevada markets increased by almost 14 percent relative to a control group. These findings suggest that the merging parties exploited their resulting market power, to the detriment of consumers. [35]

Also, recent studies suggest premiums for employer sponsored fully insured plans are rising more quickly in areas where insurance market concentration is increasing.[36]

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.[37] Research suggests that on the federal health insurance exchanges, the participation of one new carrier (i.e., UnitedHealth Group Inc.) would have reduced premiums by 5.4 percent, while the inclusion of all companies in the individual insurance markets could have lowered rates by 11.1 percent.[38] 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.[39]

Medical Loss Ratio Does Not Protect Consumers

The health insurers claim that medical loss ratio (MLR) regulations will protect consumers from the anticompetitive merger consequences predicted by research. The MLR measures how much of the premium dollar goes to pay for medical claims and quality activities instead of administrative costs and marketing. Large group insurers must devote at least 85 percent of premium revenues-net of taxes and licensing fees to medical claims and quality improvement. (An 80 percent requirement applies to small group/individual plans). However, the MLR requirements do not apply to more than half of Americans under age 65 with health insurance coverage because the rules do not apply to privately-insured enrollees in self-insured plans. Also, as Professor Dafny has observed, for the regulations to constrain an exercise of market power "they must 'bind:' the statutory floors must be higher than we would otherwise see."[40] Thus, there may be substantial room for profitable merger-related price increases in the individual market in particular, notwithstanding the minimum MLR requirement. She further observes that because the MLR is calculated at the state and market level, it is conceivable that mergers can enable insurers to offset low MLRs in one geographic area or sub-segment with high MLR in another.[41] In addition, the MLR does not address the level of the premium increase, only the percentage used for claims and quality activities. Finally, MLR regulation does not address non-price dimensions of health insurer competition such as product design, provider networks, and customer service. Therefore the MLR does not protect consumers from post-merger harm along "value" dimensions.

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[35] 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.
[36] Dafny, supra note 15, at 11.
[37] Dafny et al., supra note 34.
[38] "More Insurers, Lower Premiums? Evidence from Initial Pricing in the Health Insurance Marketplaces," *Kellogg Insight* (July 7, 2014), http://insight.kellogg.northwestern.edu/article/more_insurers_lower_premiums.
[39] Dafny, supra note 15, at 11.
[40] Dafny, Id., at 14.
[41] Id.

Plan Quality

The mergers 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.[42] As Professor Dafny observes, "the competitive mechanisms linking diminished competition to higher prices operate similarly with respect to lower quality."[43]

Merger Efficiency Claims are Unsupported and Speculative

Professor Dafny noted in her Senate testimony that claims of offsetting efficiencies cannot ameliorate the competitive harm from these mergers. "Efficiencies must be merger-specific and verifiable…and there is still the question of whether benefits will be passed through to consumers in light of that diminished competition."[44] Insurers have a dismal track record of passing any savings from an acquisition on to consumers, and there is no reason to believe that this transaction would be any different. Under these circumstances, we suggest that the DOJ review the merging insurers' efficiency claims with skepticism similar to that expressed by the Ninth Circuit Court of Appeals in the merger case of *St. Alphonsus Medical Center and Federal Trade Commission v. St. Luke's*, 778 F.3d 775 (9th Cir, 2015). ("The Supreme Court has never expressly approved an efficiencies defense to a section 7 claim…We remain skeptical about the efficiencies defense in general and about its scope in particular.")[45]

Turning to the health insurers' specific efficiency claims, "[t]here is no evidence that larger insurers are more likely to implement innovative payment and care management programs…[and] there is a countervailing force offsetting this heightened incentive to invest in…reform: more dominant insurers in a given insurance market are less concerned with ceding market share."[46] 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.[47]

In any event, the vague "innovative payment" and "care management" claims made by the health insurers in their Congressional testimony are undermined by the studies of consummated health insurance mergers discussed above, which show that the mergers actually resulted in harm to consumers in the form of higher, not lower, insurance premiums.

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[42] *See* R. Town and S. Liu, supra note 6.
[43] Dafny, supra note 15, at 11.
[44] Id. at 16.
[45] *St. Alphonsus Medical Center and Federal Trade Commission v. St. Luke's*, 778 F.3d 775, 789-790 (9th Cir, 2015)
[46] Dafny, supra note 15, at 16.
[47] Id.

Countervailing Power Is Not a Consumer Welfare Enhancing Efficiency

Several scholars have observed that one of the motivations for the health insurer mergers is to respond to hospital consolidation by acquiring countervailing power to force hospital prices down to the benefit of consumers.[48] There is, however, no economic evidence that the formation of bilateral hospital/health insurer monopolies—a battle between proverbial Sumo wrestlers—benefits consumers. Professor Greaney observes that such matches often end in a handshake and consumers get crushed.[49] The better answer to hospital consolidation is to recognize that integrated care does not necessarily require hospital-led consolidation and that by encouraging entry into hospital markets, hospital markets can be made competitive.

Fortunately, regulators can take steps to encourage new entry.[50] Low-hanging fruit in this area would be removing barriers to health care market entry that the government itself has erected. These include strengthening and expanding program integrity exemptions for physicians participating in alternative payment and delivery models, more flexible antitrust enforcement policies to foster physician networks engaged in alternative payment models (APMs) and the elimination of state certificate of need (CON) laws and the ban placed by the ACA on physician-owned specialty hospitals (POH). This latter restriction is radically inconsistent with the general thrust of the ACA, which is to encourage competition, such as the creation of health insurance exchanges and the formation of new delivery systems.

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

Just as the proposed mergers would enable the merged firms to raise premiums or reduce levels of service, they 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 such that the mergers would violate section 7 of the Clayton Act.

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,[51] and the merger of UnitedHealth Group Inc. and Pacific Care in Tucson, Arizona and in Boulder, Colorado in 2005.[52]

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

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[48] See Prof. Mark Pauly of the Wharton School at *Health Care Management Professor Mark Pauly PhD Discusses Proposed Health Care Insurance Company Mergers*, available at: http://knowledge.wharton.upenn.edu/article/whats-driving-health-insurers-merger-mania/, and Prof. Thomas Greaney, "*Examining Implications of Health Insurance Mergers*," available at: http://healthaffairs.org/blog/2015/07/16/examining-implications-of-health-insurance-mergers/.

[49] Greaney, "Examining Implications of Health Insurance Mergers."

[50] Id.

[51] *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*.

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

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."[53]

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."[54] Health insurer monopsonists typically are also monopolists.[55] Facing little if any competition, they lack the incentive to pass along cost savings to consumers. Also, the demand for health insurance is inelastic—when the price is raised, the insurer's total revenue increases, and when price falls so do total revenues.[56]

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,[57] 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."[58] 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.[59]

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. It may also force physicians to spend less time with patients to meet practice expenses. Mergers may also cause even tighter provider networks, reducing patient access to physicians and effectively curtailing the quantity of their services. When one or more health insurers dominate a market, physicians can be pressured not to engage in aggressive patient advocacy, a crucial safeguard of patient care.

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[53] 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.

[54] Dafny, supra note 15, at 9.[55] Peter J. Hammer and William M. Sage, *Monopsony as an Agency and Regulatory Problem in Health Care*, 71 ANTITRUST. L.J. 949 (2004).

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

[56] Su Liu & Deborah Chollet, supra note 39.

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

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

[59] Id.

Verifying the threat to consumers, a consumer representative testified in the Senate Judiciary Committee hearing on the mergers that they could "force doctors and hospitals to go beyond trimming costs, to cut costs so far that it begins to degrade the care and service they provide below what consumers value and need."[60]

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.[61] Recent projections by the Health Resources and Services Administration similarly suggest a significant shortage of primary care physicians in the United States.[62]

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.[63] According to the Deloitte survey, 57 percent of physicians also said that the practice of medicine was in jeopardy and nearly 75 percent of physicians thought that the "best and the brightest" may not consider a career in medicine. Finally, most physicians surveyed believed that physicians would retire or scale back practice hours, based on how the future of medicine is changing.[64]

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

Mergers resulting in monopsony power within the MA market 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 MA market where the lack of competition enables insurers to depress fees paid to physicians for services under MA.

DOJ Should Block the Mergers to Protect the Quality and Quantity of Physician Services

Given that the proposed mergers would result in countless highly concentrated commercial and MA markets where the merged entities either possessed substantial market shares or could exercise buyer power through coordinated interaction, it is critical for antitrust enforcers to oppose the proposed mergers

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[60] Statement of George Slover, Senior Policy Counsel, Consumers Union, Hearing of the Senate Committee on the Judiciary (September 22, 2015), *available at*: http://www.judiciary.senate.gov/meetings/examining-consolidation-in-the-health-insurance-industry-and-its-impact-on-consumers.

[61] *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.

[62] *See* health resources and services administration, projecting the supply and demand for primary care physicians through 2020 in brief (November 2013).

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

[64] Id.

so that physicians have adequate competitive alternatives. Unless successfully opposed, the merged entities would likely be able to lower payment rates for physicians to a degree that would reduce the quality or quantity of services that physicians offer to patients.

REMEDIES: DIVESTITURES WOULD BE UNWORKABLE AND INADEQUATE TO PROTECT CONSUMERS

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

As a practical matter, the overwhelming number of markets adversely affected by the proposed mergers, along with the barriers to entry to health insurance most recently demonstrated by the failure of the federally subsidized co-op program, makes unlikely that the DOJ 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.

Also troublesome is the apparent absence of a viable divestiture remedy in a national market where five national insurers compete for employer contracts. There are no would-be purchasers with the size and scope of the existing five national insurers that could replace the lost national competition.

Accordingly, the AMA respectfully urges DOJ to block the mergers in order to protect consumers from premium increases, lower plan quality, and a reduction in the quantity and quality of physician services. We thank the Antitrust Division for its vigilant merger enforcement and look forward to helping augment your analysis with data and insights gleaned from our studies of health insurance markets.

Sincerely,

James L. Madara, MD