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Chairman Sevigny:

Please find the enclosed white paper to facilitate the discussion on the health insurance mergers of Anthem and Cigna and Aetna and Humana for my November 20, 2015 presentation before the Health Insurance and Managed Care (B) Committee. As the paper explains, both the National Association of Insurance Commissioners (“NAIC”) and each state’s Insurance Commissioner are empowered to formally and publicly investigate health insurance mergers. Given the size of these specific transactions and the potential post-merger(s) anticompetitive effects, it is critical that the Insurance Commissioners act within their powers to carefully scrutinize these mergers. And I suggest that the NAIC form a task force or working group of several Insurance Commissioners to address these mergers.

I thank the Health Insurance and Managed Care (B) Committee for giving me the opportunity to present my findings and provide insight into the health insurance merger review process.

Sincerely,



David Balto

Cc: Vice Chairman Mike Kreidler
Commissioner Andy Tobin
Commissioner Marguerite Salazar
Commissioner Katharine L. Wade
Commissioner Mike Rothman
Commissioner Laura N. Cali
Commissioner Teresa D. Miller
Commissioner Angela Weyne
Commissioner Todd E. Kiser
Commissioner Jacqueline K. Cunningham
Commissioner Ted Nickel
Commissioner Tom Glause

Health Insurance Mergers: The Vital Role of State Insurance Commissioners in Investigating Anthem-Cigna and Aetna-Humana

Executive Summary

The recently announced mergers between Anthem and Cigna and Aetna and Humana will be reviewed by numerous state Insurance Commissioners. Insurance Commissioners and the National Association of Insurance Commissioners (“NAIC”) are empowered by law to review, investigate, and where necessary, disapprove anticompetitive health insurance mergers. This white paper examines the health insurance merger review process and highlights the following:

- If these mergers were consummated, the number of national competitors would be reduced from five to three. Anthem would have 53 million enrollees and Aetna would have 37 million enrollees. Including UnitedHealth, these three insurers would cover nearly 140 million lives or 51.3 percent of all Americans with insurance.
- A state’s Insurance Commissioner is authorized to review health insurance mergers under their state’s Insurance Holding Company System Regulatory Act.
- A Commissioner’s investigation of a health insurance merger provides a critical and unique scope, different from antitrust investigations done by other entities including the U.S. Department of Justice (“DOJ”) and the states’ attorneys general.
- The Commissioner is not beholden to the competitive analysis done by others.
- Under the NAIC’s Model Act, to approve a merger, a Commissioner must determine that several conditions are met including that the merger would not “substantially lessen competition in insurance in this state or tend to create a monopoly.”
- The Model Act standards differ from the standards applied by the DOJ, and those standards have primacy in Insurance Commissioner investigations.
- The Model Act prevents anticompetitive health insurance mergers in concentrated markets, in markets with a trend towards concentration, and in markets with substantial evidence of competitive harm.
- The Model Act also prevents health insurance mergers that are prejudicial to policyholders or to the insurance-buying public.
- Commissioners have broad powers to conduct investigations and hold hearings. Unlike the DOJ process, the inquiry is public and the Commissioner has broad powers to secure information from parties, hold public hearings, secure information, issue subpoenas, and conduct a broad inquiry on the effects of the merger. The Commissioner can hire experts to assist in the inquiry at the expense of the parties. Third parties can have the power of fully participating in hearings, including questioning witnesses and securing information.
- State Insurance Commissioners have greater expertise in competitive and consumer protection issues in their state than federal regulators such as the DOJ.

**Attached to this submission is Appendix A, B, and C. Appendix A provides a short overview of a number of different health insurance matters involving Insurance Commissioners. Appendix B offers a map, based on available data, of potential anticompetitive overlaps from the mergers of Anthem-Cigna and Aetna-Humana. Appendix C contains a list of valuable sources the NAIC and Insurance Commissioners should review as part of their investigations into the two mergers.

- State Insurance Commissioners have broader tools to remedy the potential competitive impact of mergers.
- The existence of concentrated insurance markets under the Model Act and DOJ Merger Guidelines is *prima facie* evidence of competitive harm.
- In order to effectively and comprehensively assess the impact of these mergers, we recommend that NAIC form a task force or working group so that states can collectively analyze these mergers and develop and share expertise.

This paper addresses several topics. First, it provides a short analysis of the Anthem-Cigna and Aetna-Humana mergers. Second, it analyzes the broad powers of an Insurance Commissioner to review a health insurance merger. Third, it offers an overview of the antitrust review of health insurance mergers. Finally, it provides two recommendations: (1) each Insurance Commissioner should investigate the mergers where appropriate, and (2) the NAIC should form a task force or working group dedicated to health insurance mergers and supporting Insurance Commissioners.

I. The Mergers: Anthem and Cigna and Aetna and Humana¹

The health insurance mergers of Anthem-Cigna and Aetna-Humana would eliminate two of the U.S.'s five national insurers.² The parties cover a substantial number of lives across a broad range of insurance products. A combined Anthem and Cigna would have 53 million beneficiaries, and a combined Aetna and Humana would have 37 million.³ Including UnitedHealth's nearly 46 million beneficiaries,⁴ the three largest health insurance companies in the United State would have nearly 140 million enrollees or 51.3 percent of individuals with health insurance coverage nation-wide.⁵

II. Health Insurance Commissioners' Reviewing Power

Along with the Department of Justice Antitrust Division ("DOJ") and the states' attorneys general, the states' Insurance Commissioners serve a critical role in investigating and reviewing mergers between health insurers. However, unlike the other agencies and enforcers, the Insurance Commissioners' powers allow them to fully analyze the health insurance market within their state, both broadening the scope of the investigation into potential competition issues and considering additional factors outside of typical antitrust jurisprudence. Most importantly, the Commissioner's review is *independent* of those done by other regulators and enforcers. A Commissioner is not beholden to the competitive analysis done by others. The Insurance Commissioners derive their health insurance merger review powers from state statutes modeled on the National Association of Insurance Commissioners' Model Insurance Holding Company System Regulatory Act ("Model Act").⁶ While there are variations among states, all states have adopted some version of the Model Act.

The Model Act requires mergers between insurance companies to receive approval from the Commissioner in each state in which the newly merged firm will operate.⁷ After a "public hearing,"⁸ the Commissioner must not approve an insurance merger or transaction if: (a) the merged party could not "satisfy the requirements for the issuance of a license"; (b) the merger would "substantially lessen competition in insurance in this state or tend to create a monopoly"; (c) the financial condition of the acquiring party may "jeopardize the financial stability of the insurer, or prejudice the interest of policy holders"; (d) the acquiring party's plans are unfair or unreasonable to policyholders of the merging party and "not in the public interest"; (e) the "persons who would control the operation of insurer" lack "experience and integrity"; or (f) "the acquisition is likely to be hazardous or prejudicial to the insurance-buying public."⁹

¹ I would like to thank my associate James Kovacs for assisting me in writing this white paper.

² Walker Ray & Tim Norbeck, *When It Comes to Health Insurance Mergers, Bigger is not Going to be Better*, FORBES.COM (Sept. 28, 2015), <http://goo.gl/Z3EhI4> (UnitedHealth is the fifth national insurer).

³ Margaret Patrick, *Aetna Announces Its Acquisition of Humana*, MARKET REALIST (July 8, 2015), <http://goo.gl/C6aJ1p>.

⁴ *Id.*

⁵ *Health Insurance Coverage of the Total Population*, KAISER FAMILY FOUNDATION, <http://goo.gl/6VnFA>.

⁶ MODEL INS. HOLDING CO. SYS. REGULATORY ACT § 440-1 (Nat'l Ass'n of Ins. Comm'rs 2015) [hereinafter "Model Act"].

⁷ Model Act at § 3 (D).

⁸ *Id.* at § 3 (D)(1).

⁹ *Id.* at § 3 (D)(1)(a-f). A finding of anyone of the six factors in the Model Act is sufficient to deny a merger.

For the purpose of this paper, I will primarily focus on the competitive analysis – whether the merger would substantially lessen competition in insurance or tend to create a monopoly.

A. *Competitive Standard under the Model Act*

According to the Model Act’s “Competitive Standard,”¹⁰ there are multiple ways in which a merger may substantially lessen competition or tend to create a monopoly. First, the Commissioner has a *prima facie* case to block an insurance merger if the market is highly concentrated, defined as the four largest insurers having a 75 percent or greater market share,¹¹ and the merging parties having the following market shares:

| Insurer A ¹² | Insurer B |
|-------------------------|-------------------|
| 4 percent | 4 percent or more |
| 10 percent | 2 percent or more |
| 15 percent | 1 percent or more |

Second, the Model Act also deems insurance mergers presumptively anticompetitive in non-concentrated markets when insurers have the following market shares:

| Insurer A ¹³ | Insurer B |
|-------------------------|-------------------|
| 5 percent | 5 percent or more |
| 10 percent | 4 percent or more |
| 15 percent | 3 percent or more |
| 19 percent | 1 percent or more |

While merger proponents often disregard the market shares adopted in the Model Act, indicating that a merger is presumptively anticompetitive, those statutory market share thresholds must be taken seriously. To be sure, federal antitrust law today is not based on the market share thresholds in the Model Act: the DOJ is not troubled by proposed mergers at or even substantially above those thresholds. But, federal law does not preempt the Model Act. The market share thresholds it contains are rebuttable by clear and convincing evidence, and they must be the starting point for the Commissioner’s antitrust analysis. They cannot be ignored.

Third, there is also a rebuttable presumption of a violation if the state has a “significant trend toward increased concentration.”¹⁴ A concentration trend occurs when the aggregate market share of any grouping of the state’s largest insurers, from the two largest to the eight largest, has increased by seven percent or more over a five to ten year period.¹⁵ Under the concentration standard, there is a *prima facie* evidence of a violation if one of the merging insurers is in the

¹⁰ *Id.* at § 3.1 (D).

¹¹ *Id.* at § 3.1 (D)(2)(a)(ii).

¹² *Id.* at § 3.1 (D)(2)(a)(i).

¹³ *Id.* at § 3.1 (D)(2)(a)(ii).

¹⁴ *Id.* at § 3.1 (D)(2)(b).

¹⁵ *Id.*

group of large insurers “showing the requisite increase in market share” and the other merging party has at least a two percent market share.¹⁶

Finally, the Commissioner may also go outside of the “Competitive Standard” and prevent a merger if there are “anticompetitive effect[s] based upon other substantial evidence.”¹⁷ The Commissioner may rely on any number of factors including: “market share, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry and exit into the market.”¹⁸

B. Prejudicial to the Public Interest

Along with the “Competitive Standard,” in evaluating an insurance merger, the Commissioner must also consider factors in addition to the merger’s likely effect on competition. The Commissioner must determine that an insurance merger does not “prejudice the interest of its policyholders” or that it is not “prejudicial to the insurance-buying public.”¹⁹ Thus, even if the Commissioner finds that a merger would not tend substantially to lessen competition, it would still be subject to disapproval if it would have other adverse effects on policyholders or the public.

For example, one area that Commissioners have considered in connection with merger applications, and which was a factor in the Commissioners’ disapproval of proposed mergers,²⁰ is change in control payments receivable in connection with the merger. In the attempted WellPoint acquisition of CareFirst, the Maryland Insurance Commissioner rejected the acquisition and conversion of CareFirst in part because change in control payments would grant CareFirst officers significant remuneration, which was not in the interest of the insured public of Maryland.²¹ While such payments are not relevant to the antitrust analysis conducted by the DOJ, Insurance Commissioners do have the authority to consider them in determining whether a transaction would be prejudicial.²²

C. Advantages of Model Act and State Insurance Commissioner Review

The Model Act provides Insurance Commissioners with a number of significant advantages over their federal and state counterparts. First, the insurance merger review process is done in public. While the DOJ and states’ attorneys general work behind closed doors, an Insurance Commissioner is required by law to hold a public hearing on an insurance merger.²³ The public hearing process has a number of unique advantages, including authorizing testimony from and participation in the hearing process by third parties and experts. Moreover, the public nature of

¹⁶ *Id.* at § 3.1 (D)(2)(b)(ii-iii).

¹⁷ *Id.* at § 3.1 (D)(2)(d).

¹⁸ *Id.*

¹⁹ *Id.* at § 3 (D)(1)(c-f).

²⁰ *See In re The Consolidated Application for the Conversion of CareFirst, Inc. and CareFirst of Maryland, Inc to For-Profit Status and the Acquisition of CareFirst, Inc. by WellPoint Health Networks, Inc.*, MIA No. 2003-02-032 at 3-4 (Mar. 5, 2003).

²¹ *Id.*

²² *See Id.* at § 3 (D)(4).

²³ *Id.* at § 3 (D)(1).

the process does not limit the competitive analysis. Much like the DOJ, an Insurance Commissioner may still collect documents, interview witnesses, and gather economic data. Moreover, a Commissioner has the power to hire economists, expert witnesses, and other counsel, at the expense of the parties, to conduct the investigation.

Pennsylvania's investigation of the Highmark-Independence Blue Cross merger is an example of the breadth of the Insurance Commissioner's powers under the Model Act. The review took over two years.²⁴ As part of the merger investigation, the Pennsylvania Insurance Department held extensive public hearings and analyzed thousands of pages of documents. It received testimony from consumers, competing insurers, health care providers, and payors. It hired both legal and economic experts who conducted an independent analysis of the competitive effect of the transaction. The Commissioner attempted to negotiate a remedy but ultimately concluded the transaction would be anticompetitive for the Commonwealth of Pennsylvania, and eventually, the transaction was abandoned by the parties.²⁵ It is also worth noting that the Department of Justice did not oppose the merger.

Second, the Insurance Commissioners have significant remedial powers. The DOJ has only relied on the divestiture remedy, or the sale of problematic assets to a functioning competitor, in settling health insurance mergers.²⁶ In insurance markets, the divestiture remedy has its limits. As noted in two separate economic studies, the divestiture remedy does not necessarily prevent the newly formed insurer from raising premiums.²⁷ Attached to this white paper is Appendix A, which contains a summary of the different types of relief Insurance Commissioners have ordered in merger matters, including blocking the merger outright, ordering a divestiture, and implementing conduct and regulatory remedies.²⁸ In all of the cited cases, the remedies went beyond those ordered by the DOJ. Along with the remedies cited in Appendix A, an Insurance Commissioner can utilize his or her power to order any number of potential remedies including setting benchmark prices, ensuring that *both merging parties* continue to offer competing insurance products within the state, employing a global budget so that overall spending is constrained, and rigorous rate review for the merging entities.

Third, the Model Act gives the Insurance Commissioner the power to look at a broader range of competitive and consumer protection concerns beyond that available under federal antitrust review. Along with the lessening of competition as defined by the DOJ, a health insurance merger can have other anticompetitive impacts. The Model Act was written to ensure that an Insurance Commissioner's merger investigation would not only review direct competition

²⁴ See *Highmark Merger Timeline*, PENNSYLVANIA INSURANCE DEP'T, <http://goo.gl/0b6827> (last visited Nov. 15, 2015); see also Press Release, Joel Ario on Highmark and IBC Consolidation (Jan. 22, 2009).

²⁵ *Id.* The case is further discussed in attached Appendix A.

²⁶ See Revised Final Judgement, *United States v. Aetna Inc. and Prudential Insurance Co. of Am.*, No. 3-99CV 1398-H (N.D. Tex. Dec. 7, 1999); see also Final Judgement, *United States v. UnitedHealth Group Inc. and Sierra Health Servs. Inc.*, 1:08-CV-00322 (D.D.C. Sept. 24, 2008); see also Final Judgment, *United States v. Humana Inc.*, No. 1:12-cv-00464 (D.D.C. March 27, 2012).

²⁷ See Leemore Dafny, Mark Duggan, & Subramaniam Ramanarayanan, *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, 102 AM. ECON. REV. 1161, 1163 (2012); see also José R. Guardado, David W. Emmons, & Carol K. Kane, *The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra*, 1 HEALTH MGMT., POL'Y & INNOVATION 16, 21 (2013).

²⁸ Appendix A is not a complete list of all health insurance merger matters remedied by Insurance Commissioners.

between the parties but also trends in concentration within the state, the financial viability of the parties, potential changes in coverage for citizens, and entry and exit of other insurers.

Finally, and perhaps most important, an Insurance Commissioner has vastly greater expertise in local health insurance markets than the DOJ. DOJ health insurance investigations are episodic and very narrow. State Insurance Commissioners regulate insurance products and deal directly with consumers and payors on a daily basis. They have years of enforcement actions and know the competitive dynamics of the markets. Given their knowledge of both the insurers doing business in their state and the characteristics of their state's health insurance market, Insurance Commissioners are uniquely qualified to investigate and remedy competitive harms from proposed mergers within their borders.

III. DOJ Health Insurance Merger Antitrust Analysis

The Model Act and state insurance laws provide a framework for health insurance merger reviews with the burden of showing *prima facie* evidence of a competitive violation “rest[ing] upon the commissioner.”²⁹ One can expect that the merging parties will want to rely on the approach used by the Department of Justice under the Clayton Act Section 7³⁰ and the Merger Guidelines.³¹ These standards are instructive, but an Insurance Commissioner is not compelled to follow these standards.³²

A. Market Definition

Under the Merger Guidelines, the starting point for analysis involves the relevant market definition. This includes both a product and geographic component.³³ Under the Model Act, the default relevant market is presumed to be “the direct written insurance premium for a line of business, such line being that used in the annual statement required by to be filed by insurers doing business in the state, and the relevant geographical market is assumed to be this state.”³⁴ However, the Model Act also instructs the Commissioner to give “consideration to, among other things... information, if any, submitted by parties to the acquisition.”³⁵

With those caveats in mind, an analysis under the Merger Guidelines defines a relevant product market as the competing products that can be used to substitute for one another. Given the nature of health insurance and the lack of product substitution, in health insurance merger cases, product markets are often defined as individual insurance products. For example, in the DOJ’s complaint challenging the merger of Aetna and Prudential, the relevant product market was defined as health maintenance organization (“HMO”) and preferred provider organization

²⁹ Model Act at § 3.1 (D)(2)(c)(iii).

³⁰ Clayton Act § 7, 15 U.S.C. § 18 (2000).

³¹ Dep’t of Justice and Fed. Trade Comm’n, *Horizontal Merger Guidelines* at § 4 (2010), available at <https://goo.gl/dM9kgh> [hereinafter “Merger Guidelines”].

³² In fact, courts have held that the Merger Guidelines are not the law, but they are instructive of competitive analysis. See, e.g., *Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410, 431 n.11 (5th Cir. 2008) (“Merger Guidelines are often used as persuasive authority when deciding if a particular acquisition violates anti-trust laws.”).

³³ Merger Guidelines at § 4.

³⁴ Model Act at § 3.1 (D)(2)(c)(ii).

³⁵ *Id.*

(“PPO”) plans.³⁶ In the 2008 complaint challenging the UnitedHealth-Sierra merger, the DOJ defined the product market as Medicare Advantage plans.³⁷

Relevant geographic markets are the boundaries that limit consumer substitute of products in the event the merged entity attempts to raise price.³⁸ For health insurance markets, relevant markets can be as broad as the nation or as limited as a metropolitan market. Given that consumers typical want access to providers close to where they live and work, some geographic markets for health insurance are local, often defined as metropolitan statistical areas.³⁹ Geographic markets can also vary based on insurance product. In the DOJ’s challenge of Humana’s acquisition of Arcadian, the product market was defined as Medicare Advantage plans which are approved to be sold by “county or parish.”⁴⁰ Therefore, in their complaint against the merger, the DOJ defined the relevant geographic markets by state counties throughout the United States.⁴¹

With the two current mergers, there are significant overlaps in a number of states and local geographic areas.⁴² Geographic markets could be defined as a metropolitan area, a state, or even a national market. With the significant product overlaps, there are also a range of potential product market definitions. In the Aetna and Humana merger, along with overlaps in a number of commercial individual insurance product markets, there is significant concern within the Medicare Advantage space. A combination would create the largest Medicare Advantage insurer in the United States.⁴³

For Anthem and Cigna, both companies have overlaps in the individual market, but they also have significant presence in offering plans to national employers.⁴⁴ Moreover, given Anthem’s affiliation as a Blue Cross license holder in 14 different states, market definition and analysis will have to include overlaps in products with Blue Cross Blue Shield plans throughout the United States.⁴⁵ In addition, the Blue Cross Association imposes limits on the amount of non-Blue-branded business a Blue plan can do, thus raising additional competitive concerns regarding the Anthem and Cigna merger.⁴⁶

³⁶ See Complaint, *United States v. Aetna Inc.*, No. 3-99-CV-1398-H (N.D. Tex. June 21, 1999).

³⁷ See Complaint, *United States v. UnitedHealth Group Inc.*, 1:08-CV-00322 (D.D.C. Feb. 25, 2008).

³⁸ See Merger Guidelines at § 4.

³⁹ See Complaint, *Aetna Inc.*, *supra* note 36.

⁴⁰ See Complaint, *United States v. Humana Inc.*, No. 1:12-cv-00464 (D.D.C. March 27, 2012).

⁴¹ *Id.* (the DOJ found that the merger would substantially lessen competition for Medicare Advantage plans in 51 separate counties in a number of states).

⁴² Letter from Consumer Federation of America, U.S. Public Interest Research Group, Alliance for a Just Society, Consumer Action, CT Citizen Action Group, DC-37, Main Street Alliance, Sergeants Benevolent Association, & Virginia Rural Health Association to Chairman Michael S. Lee, Senate Judiciary Subcomm. on Antitrust, Competition Policy, and Consumer Rights (Sept. 21, 2015), available at <http://goo.gl/TvI2ml> (noting that there are a large number of overlaps at the local, state, and national level).

⁴³ See Bruce Japsen, *Hospitals Say Aetna-Humana Deal Endangers Medicare Advantage*, FORBES.COM (Sept. 2, 2015 12:38 PM), <http://goo.gl/tvQZvm>.

⁴⁴ See Anna Wilde Mathews & Brent Kendall, *Health Insurers Aetna, Anthem Defend Deals, Say Markets Will Stay Competitive*, WALL ST. J. (Sept. 22, 2015 12:48 PM), <http://goo.gl/so8QcH>.

⁴⁵ See Letter from Joe R. Whatley, Jr., Edith M. Kallas and Henry C. Quillen to William Baer, Assistant Attorney General, U.S. Dept. of Justice Antitrust Division (Aug. 13, 2015).

⁴⁶ *Id.* (known as the two-thirds rule that requires each Blue plan to generate two-thirds of its annual revenue through business associated with the Blue mark).

B. *Competition within Markets--Market Concentration and Other Factors*

Market concentration focuses on the changes in share and concentration within the defined relevant product market. As previously detailed, the Model Act provides standards as to what is deemed “highly concentrated” and if a merger would “substantially lessen competition or tend to create a monopoly.”⁴⁷ The existence of market concentration, as defined under the Model Act, is *prima facie* evidence that a health insurance merger is anticompetitive.⁴⁸

The Merger Guidelines apply a market concentration calculation using the Herfindahl-Hirschman Index (“HHI”).⁴⁹ HHI is used as a measure of the size of firms in relation to the industry and as an indicator of the amount of competition among them. HHI is calculated by summing the squares of the individual firms’ market shares. HHI ranges from 0 to 10,000, and based on their HHI scoring, the enforcement agencies classify markets into three types: (1) unconcentrated, (2) moderately concentrated, and (3) highly concentrated.⁵⁰ A merger between market competitors increases concentration within a relevant market. According to the enforcement agencies, mergers within concentrated markets can raise antitrust concerns. See the chart below:

| Market Type | HHI (pre-merger) | Change in HHI (post-merger) |
|-------------------------|-------------------------|--|
| Unconcentrated | Below 1,500 | Mergers resulting in unconcentrated markets are unlikely to have adverse competitive effects and ordinarily require no further analysis. |
| Moderately Concentrated | Between 1,500 and 2,500 | Mergers resulting in moderately concentrated markets that involve an increase in the HHI of more than 100 points potentially raise significant competitive concerns and often warrant scrutiny. |
| Highly Concentrated | Above 2,500 | Mergers resulting in highly concentrated markets that involve an increase in the HHI of between 100 points and 200 points potentially raise significant competitive concerns and often warrant scrutiny. Mergers resulting in highly concentrated markets that involve an increase in the HHI of more than 200 points will be presumed to be likely to enhance market power. ⁵¹ |

⁴⁷ See *supra* Section II(A).

⁴⁸ Model Act at § 3.1 (D)(2)(a).

⁴⁹ Merger Guidelines at § 5.3.

⁵⁰ *Id.*

⁵¹ *Id.*

As with the Model Act, the existence of high concentration under HHI measurements can establish a presumption that a merger is anticompetitive.⁵² Using the HHI guidelines, analysis of commercial health insurance markets shows that “seven out of ten metropolitan areas” are highly concentrated.⁵³ A recent study also concluded that 97 percent of all Medicare Advantage markets are highly concentrated.⁵⁴

There is a wealth of data concerning insurance market shares. According to the non-partisan Kaiser Family Foundation, on average, a state’s largest insurer controls 55 percent of the individual, commercial health insurance market.⁵⁵ There are also few competitors to challenge dominant, incumbent insurers. States only average three total insurers with a greater than five percent market share within their borders.⁵⁶ Mergers between insurers with substantial market shares can be deemed anticompetitive.⁵⁷

The mergers of Anthem-Cigna and Aetna-Humana pose significant and substantial overlaps in a number of insurance products across a number of different states. Relying on data from the American Medical Association and using HHI analysis, the mergers will substantially lessen competition in 154 metropolitan areas within 23 different states.⁵⁸ Other sources have corroborated these findings.⁵⁹ Analysis from the Kaiser Family Foundation found that the merger of Aetna and Humana would create an entity with a greater than 50 percent market share for Medicare Advantage plans in over ten states.^{60,61}

⁵² See *St. Alphonsus Med. Ctr. v. St. Luke’s Health Sys.*, 778 F.3d 775, 788 (9th Cir. 2015) (stating that “the extremely high HHI on its own establishes the *prima facie* case.”).

⁵³ See *The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act’s Impact on Competition: Hearing before the Comm. on the Judiciary Subcomm. on Regulatory Reform, Commercial and Antitrust Law*, 114th Cong. 7 (Sept. 10, 2015) (testimony of Barbara L. McAneny, Am. Med. Assoc.), available at <http://goo.gl/bdERnm>.

⁵⁴ See Brian Biles, Giselle Casillas & Stuart Guterman, *Competition Among Medicare’s Private Health Plans: Does It Really Exist?*, COMMONWEALTH FUND at 1 (Aug. 25, 2015), available at <http://goo.gl/nLcrud>.

⁵⁵ *Individual Insurance Market Competition*, KAISER FAMILY FOUNDATION (2015), <http://goo.gl/tVRmL3>.

⁵⁶ *Id.*

⁵⁷ See Press Release, Dep’t of Justice, Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans (Mar. 8, 2010), available at <http://goo.gl/PaUAhC> (Blue Cross Blue Shield of Michigan with a 70 percent market share in Lansing and Physicians Health Plan of Mid-Michigan with a 20 percent market share abandoned their merger after the DOJ threatened to litigate).

⁵⁸ Press Release, Am. Med. Assoc., AMA Releases Analyses on Potential Anthem-Cigna and Aetna-Humana Mergers (Sept. 8, 2015), available at <http://goo.gl/3TZoJn>.

⁵⁹ See *Effects on Competition of Proposed Health Insurer Mergers: Hearing before Comm. on the Judiciary Subcomm. on Regulatory Reform, Commercial and Antitrust Law*, 114th Cong. 5-8 (Sept. 29, 2015) (testimony of Edmund F. Haislmaier, Heritage Foundation), available at <http://goo.gl/9E2Dkm> (offering listing of overlaps in different product markets across numerous states).

⁶⁰ Gretchen Jacobsen, Anthony Damico, & Tricia Neuman, *Data Note: Medicare Advantage Enrollment, by Firm, 2015*, KAISER FAMILY FOUNDATION (July 14, 2015), <http://goo.gl/g1rJ0Z>.

⁶¹ Attached to this white paper is Appendix B. Appendix B contains a “Health Insurance Mergers Map” with details on states with potential anticompetitive overlaps.

C. *Competitive Effects – Unilateral Effects, Coordinated Effects, and Potential Competition*

Under the Merger Guidelines, calculating market shares is an important step. However, to determine whether a merger is anticompetitive, the Merger Guidelines instruct that the DOJ should describe how a merger may lead to higher prices and less output, innovation or service.

There are two theories of anticompetitive effects, unilateral and coordinated. Unilateral effects are non-coordinated effects that occur as competition between firms is eliminated.⁶² In other words, because of the merger, a firm will have greater unilateral power to raise price or reduce output, service, or innovation. Often, this is demonstrated by a firm having a substantial market share typically above 30 percent. In other cases, unilateral effects may occur because two firms are each other's closest competitors, even if the combined market share is below 30 percent.

There is evidence past health insurance mergers have led to unilateral anticompetitive effects – including significant premium increases.⁶³ One econometric study investigated the 1999 Aetna and Prudential merger in 139 separate markets over an eight-year span. The authors determined that the resulting increase in market concentration post-merger “raised premiums by roughly 7 percent.”⁶⁴ A second study investigated the effects of the 2008 UnitedHealth and Sierra Health Services merger and provided similar findings—post-merger, commercial premiums in Nevada increased by 13.7 percent above what they would have been absent the merger.⁶⁵ Moreover, a recent study in the *Journal of Technology Science* found that in both 2014 and 2015, the “largest insurance company in each state on average increases their rates 75 percent more than smaller insurers in the same state.”⁶⁶

A health insurance merger can also greatly increase an insurer's buying power leading to significant reductions in provider reimbursement, thus harming both access and quality of care. In the DOJ's 2005 investigation of UnitedHealth's acquisition of PacifiCare, the DOJ found that UnitedHealth's post-merger monopsony power would allow it to lower rates to providers which “would likely lead to a reduction in the quantity or degradation in the quality of physicians services.”⁶⁷

Coordinated effects involves conduct between multiple firms post-merger.⁶⁸ The diminished competition allows remaining firms to coordinate their actions to harm consumers in terms of higher prices, less service or choice or less innovation. Again, in UnitedHealth's acquisition of PacifiCare, the DOJ analyzed potential coordinated effects of the merger. Prior to the merger, as part of an agreement with Blue Shield of California, UnitedHealth had shared competitively sensitive information.⁶⁹ The merger would allow former rivals, PacifiCare and Blue Shield,

⁶² See Merger Guidelines § 6.

⁶³ See Complaint, *United States v. UnitedHealth Group Inc.*, 1:05-cv-02436 (D.D.C. Dec. 20, 2005).

⁶⁴ Dafny et al., *supra* note 27 at 1163.

⁶⁵ Guardado et al., *supra* note 27 at 21.

⁶⁶ Eugene Wang & Grace Gee, *Larger Insurers, Larger Premium Increases: Health insurance issuer competition post-ACA*, J. TECH. SCI. (Aug. 11, 2015), available at <http://goo.gl/918ULo>.

⁶⁷ See Complaint, *UnitedHealth Group Inc.*, *supra* note 63.

⁶⁸ See Merger Guidelines at § 7.

⁶⁹ See Complaint, *UnitedHealth Group Inc.*, *supra* note 63.

incentives and opportunities to coordinate and reduce competition.⁷⁰ While coordinated effects are less common, they do exist, particularly in concentrated markets with a limited number of competitors.

A final consideration for competitive effects is the Clayton Act's emphasis on not only existing competition but also potential competition. Potential competition examines what a market would look like absent the merger, with a particular emphasis on whether a merging party would have entered into and competed within a market absent the merger.⁷¹ In health insurance, potential competition should focus on a health insurer's desire and ability to enter and compete within a market offering a high quality competitive insurance product to consumers. Consolidated insurance markets may make potential competition even less likely. According to Professor Leemore Dafny, "consolidation even in non-overlapping markets reduces the number of potential entrants who might attempt to overcome price-increasing (or quality-reducing) consolidation in markets where they do not currently operate."⁷² In the past, Insurance Commissioners have considered potential competition in insurance mergers. In fact, protecting potential competition was one of the bases for the Pennsylvania Insurance Commissioner's challenge to the Highmark-Independence Blue Cross merger.⁷³

D. *Powerful Buyers*

Merger analysis must also consider the role of powerful buyers to drive down prices. In the case of insurance, dominant insurers can lower reimbursement rates for providers.⁷⁴ In certain scenarios, the ability to lower supplier prices could be deemed procompetitive. However, the impact of powerful buyers is only relevant to the competitive analysis if those lower costs are passed on to consumers in lower prices.⁷⁵ In health insurance mergers, there is no available scholarly evidence that a post-merger powerful buyer passes along any cost-savings to policyholders.⁷⁶ In fact, evidence shows that powerful insurers have been raising prices to consumers, either through higher premiums or higher deductibles.⁷⁷

The overriding concern with powerful buyers, particularly those within insurance markets, is their ability to constrain choice and implement narrow networks. Narrow networks can serve a role in ensuring that individual consumers have access to low-cost insurance options. But, if an

⁷⁰ *Id.*

⁷¹ See *FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1082 (D.D.C. 1997) (finding that "allowing the defendants to merge would eliminate significant future competition.").

⁷² *Health Insurance Industry Consolidation: Hearing before the Sen. Comm. on the Judiciary, Subcomm. on Antitrust, Competition Policy, and Consumer Rights*, 114th Cong. 15 (Sept. 22, 2015) (testimony of Professor Leemore Dafny, Professor Northwestern Uni.), available at <http://goo.gl/mhExI6>.

⁷³ See Shakeba DuBose, Jayne E. Juvan, & Frank Stevens, *Highmark and Independence Blue Cross Part Ways—Pennsylvania Regulatory Hurdles Thwart Attempted Consolidation*, AM. HEALTH LAWYERS ASS'N (April 2010), <http://goo.gl/sUFKOC>.

⁷⁴ See Victor R. Fuchs & Peter V. Lee, *A Healthy Side of Insurer Mega-Mergers*, WALL. ST. J. (Aug. 26, 2015 6:36 PM), <http://goo.gl/ZuUYv0>.

⁷⁵ Merger Guidelines § 8.

⁷⁶ See Thomas Greaney, *Examining Implications of Health Insurance Mergers*, HEALTH AFFS. (July 16, 2015), <http://goo.gl/ETT1DB>.

⁷⁷ See Robert Pear, *Many Say High Deductibles Make Their Health Law Insurance All but Useless*, N.Y. TIMES (Nov. 14, 2015), <http://goo.gl/9f1gRf>.

insurer can force consumers into a narrow network of providers and eliminate choice, there are potential harms including less access and a potential reduction in the quality of care.⁷⁸ According to a recent study by the Leonard Davis Institute of Health Economics and the Robert Wood Johnson Foundation, there is an ever-increasing usage of narrow networks within health insurance markets.⁷⁹ For example, 75 percent of individual plans in Georgia, Florida, Oklahoma and California use narrow networks that only cover 25 percent or fewer of all area physicians.⁸⁰

E. Entry

Under the Merger Guidelines, even if there are potential anticompetitive effects, a merger may be permissible if those effects will be prevented by the entry of new firms. The prospect of competitive entry into a relevant market “will alleviate concerns about adverse competitive effects only if such entry *will deter or counteract* competitive effects.”⁸¹ The three factors indicating competitive entry are: (1) timeliness, (2) likelihood, and (3) sufficiency.⁸²

DOJ has studied entry in health insurance markets and concluded that “entry defenses in the health insurance industry will be viewed with skepticism and will almost never justify an otherwise anticompetitive merger.”⁸³ Upon a review of the health insurance industry, the DOJ found that new insurers had difficulty entering consolidated markets dominated by incumbents.⁸⁴ Also, expansion by existing insurers or new insurance entry is a “Catch-22”: a new market participant “need[s] a large provider network to attract customers, but they also need a large number of customers to obtain sufficient price discounts from providers to be competitive with incumbents.”⁸⁵ Without both, entry is unlikely.

Notably, there has been some new entry in the health insurance industry since the ACA was enacted. The new entrants, however, have been almost exclusively either Consumer Operated and Oriented Plans (“CO-OPs”)⁸⁶ or vertically integrated provider health plans, and neither type of entry has succeeded. More than half of all CO-OPs have failed,⁸⁷ and others have avoided insolvency only by re-characterizing liabilities as assets through the issuance of surplus notes.

⁷⁸ See *Health Insurance Industry Consolidation: Hearing before the Sen. Comm. on the Judiciary, Subcomm. on Antitrust, Competition Policy, and Consumer Rights*, 114th Cong. 15 (Sept. 22, 2015) (testimony of George Slover, Consumers Union), available at <http://goo.gl/ojiyge> (“[b]ut a dominant insurer could force doctors and hospitals to go beyond trimming costs, to cut costs so far that it begins to degrade the care and service they provide below what consumers value and need”).

⁷⁹ Dana Polsky & Janet Weiner, *State Variation in Narrow Networks on the ACA Marketplaces*, LEONARD DAVIS INST. OF HEALTH ECON. (Aug. 2015), available at <http://goo.gl/kkCWAT>.

⁸⁰ *Id.*

⁸¹ Merger Guidelines at § 9 (emphasis added).

⁸² *Id.* at § 9.1-9.3.

⁸³ Christine A. Varney, Assistant Attorney Gen., Antitrust Div., U.S. Dep’t of Justice, Remarks as Prepared for American Bar Association/American Health Lawyers Association Antitrust Healthcare Conference (May 24, 2010), available at <http://goo.gl/rzPC0G>.

⁸⁴ *Id.*

⁸⁵ U.S. Dep’t of Justice & Fed. Trade Comm’n, *Improving Health Care: A Dose of Competition* at 254 (2004), available at <http://goo.gl/GzIuvL>.

⁸⁶ See generally *Summary of the Affordable Care Act*, KAISER FAMILY FOUNDATION (April 2013), <http://goo.gl/RT7GQj> (discussing CO-OPs as part of the Affordable Care Act).

⁸⁷ Robert Pear, Failed Co-ops Add Ammunition to G.O.P. War on Health Law, N.Y. TIMES (Nov. 3, 2015), <http://goo.gl/3BDiwq> (12 of 23 CO-OPs will not be offering insurance coverage in 2016).

And vertically integrated providers offer limited services and have not expanded “beyond their core markets.”⁸⁸

In addition, consumers shopping on the Health Insurance Exchanges continue to see limited options. For 2016, the average Exchange will offer products from just over three insurers, and in 40 percent of all U.S. counties using the Federal Exchange consumers will have access to just two insurers.⁸⁹ According to the Kaiser Family Foundation, “[w]ith fewer than 3 insurers, these counties may not benefit from insurer market competition to hold down premiums or offer plans with better value.”⁹⁰ Unfortunately, the Aetna-Humana and Anthem-Cigna mergers would exacerbate this situation: in a majority of states, at least one of the mergers would eliminate an Exchange competitor, and in several states, each merger would eliminate an Exchange competitor.⁹¹

F. *Efficiencies*

A potential benefit of mergers is the enhancement of the new company’s ability to compete, by strengthening its capacity to drive down price, improve quality, enhance services, or create new products.⁹² In merger analysis, the existence of efficiencies can be used to rebut a presumption of competitive harm. However, efficiencies must be proven to be merger-specific, cognizable, and substantiated and ultimately must result in lower prices to consumers.⁹³ Moreover, within the context of health care, the Ninth Circuit recently ruled that efficiencies allegedly leading to “better service [for] patients” were not to be considered as a part of efficiencies analysis.⁹⁴ Instead, the merging parties must use efficiencies to prove “that the prediction of anticompetitive effects from the *prima facie* case is inaccurate.”⁹⁵ Notably, under these standards, no federal appellate court has relied on efficiencies in the context of a health care merger to overturn a *prima facie* case.⁹⁶

In health insurance, possible efficiencies would lead to lower costs, improved services, higher quality, and product innovation. According to Aetna, the merger with Humana will create \$1.25 billion in “synergy opportunities” and “operating efficiencies.”⁹⁷ The key question for antitrust analysis is whether these efficiencies can be achieved outside of a merger and *if they truly benefit*

⁸⁸ Lawton R. Burns & Aditi Sen, *What We’ve Learned from Horizontal and Vertical Integration of Physicians*, THE HEALTH CARE BLOG (Apr. 25, 2014), <http://goo.gl/3OVW1d>.

⁸⁹ Cynthia Cox, Gary Claxton & Larry Levitt, *Analysis of Insurer Participation in 2016 Marketplaces*, KAISER FAMILY FOUNDATION (Nov. 3, 2015), <http://goo.gl/QcETCd>.

⁹⁰ *Id.*

⁹¹ See Anna Wilde Mathews & Christopher Weaver, *Health Mergers Could Cut Consumer Options*, WALL. ST. J. (June 21, 2015), <http://goo.gl/DRuWrg>.

⁹² Merger Guidelines at § 10.

⁹³ *Id.*

⁹⁴ *St. Luke’s Health Sys.*, 778 F.3d 775 at 791.

⁹⁵ *Id.* (The case involved a provider acquisition, St. Luke’s Health System acquiring the Saltzer Medical Group. While the transaction did not involve health insurers, the Ninth Circuit’s merger analysis, particular that of efficiencies related to health care, remains relevant to any merger within the health care sphere).

⁹⁶ David Balto and James Kovacs, *Healthcare Merger Antitrust Review: Increased Scrutiny For Any Provider Merger*, CPI ANTITRUST CHRON. 1, 4 (2015).

⁹⁷ Press Release, Aetna, Aetna to Acquire Humana for \$37 Billion, Combined Entity to Drive Consumer-Focused, High-Value Health Care (July 3, 2015), available at <https://goo.gl/dktKof>.

consumers. We have previously addressed the issue of cost-savings from provider reimbursement being passed along to consumers,⁹⁸ as well as increased consumer premiums post-health insurance mergers.⁹⁹ In both instances, there is limited evidence suggesting that lower provider reimbursement benefits consumers or that mergers between insurers lead to lower costs for consumers.

There is also limited evidence demonstrating that health insurance mergers raise quality or lead to product innovation. In her recent Congressional testimony, Professor Dafny found it speculative to argue that a health insurance merger would enhance an insurer's ability to develop and implement new value-based payment agreements, because there is no evidence an insurance merger is required to carry out such initiatives.¹⁰⁰ Moreover, at a recent conference, Dafny further noted statistical evidence shows that concentrated insurance markets often have less innovative insurance product offerings, meaning mergers between insurers will not likely lead to higher quality or more inventive insurance products.¹⁰¹

IV. Conclusion and Recommendations

The current competitive environment for purchasers of health insurance is troubling. Evidence shows that markets are highly concentrated and consumers have fewer options and continue to pay higher premiums.¹⁰² The mergers between Anthem-Cigna and Aetna-Humana are significant. If consummated, insurance markets across the United States would lose two national insurers, leaving consumers with fewer competitive options.¹⁰³ Given the available evidence and the powers available to the states' Insurance Commissioners and NAIC, we recommend the two following steps:

A. State Insurance Commissioners Investigations of the Mergers

Each state wherein Anthem and Aetna must make a filing before consummating the merger – whether Form A or a Form E – should investigate the merger to the fullest extent afforded by their state statute. By creating a public venue through hearings and testimony, Commissioners can both enable the prospective merging parties to explain the benefits of their proposed transactions to the public, and provide an opportunity for consumer groups and other third parties to present evidence and otherwise participate in the investigation process. Furthermore, while the DOJ is investigating these mergers at a national level, each Insurance Commissioner can focus on their own statewide investigation.

⁹⁸ Greaney, *supra* note 76.

⁹⁹ Dafny and Guardado, *supra* note 27.

¹⁰⁰ Dafny Testimony, *supra* note 72.

¹⁰¹ Leemore Dafny, Comments at The New Health Care Industry: Integration, Consolidation, Competition in the Wake of the Affordable Care Act (Nov. 13, 2015), available at <https://goo.gl/GNIvVj>.

¹⁰² Robert Pear, *Health Insurance Companies Seek Big Rate Increases for 2016*, N.Y. TIMES (July, 3, 2015), <http://goo.gl/zDXrSj>.

¹⁰³ See Home, Coalition to Protect Patient Choice, <http://goo.gl/tGhnlv> (last visited Nov. 15, 2015) (discussing consumer concern with the lack of competition in insurance markets and impact of Anthem-Cigna and Aetna-Humana mergers).

B. NAIC Should Form a Health Insurance Task Force or Working Group

The National Association of Insurance Commissioners plays a pivotal role in establishing the standards as well as regulatory support for Insurance Commissioners. One of the mission guidelines for the NAIC is to “promote competitive markets.”¹⁰⁴ In addition, this Committee has long been recognized for its health insurance expertise: its Mission, as set forth on the NAIC website, is “to consider issues relating to all aspects of health insurance.”¹⁰⁵ We recommend that the NAIC establish a task force or working group to study the mergers and assist individual Commissioners in their analysis of the mergers.¹⁰⁶ To study mergers involving four of the five largest national health insurers would certainly seem to be an appropriate part of the NAIC’s mission. Over the years, the Health Insurance and Managed Care (B) Committee has established a number of task forces and working groups to assess specific issues.¹⁰⁷

A closely analogous precedent for this task force or working group is the committee the NAIC established in the 1990’s on Blue Cross conversions. Notably, some states, like California and Missouri, approved such conversions only on condition that the converting Blue Cross plan establish a health-care foundation with the full value of its assets; other states approved conversions conditioned on other remedies; and still other states disapproved conversions in their entirety. The actions taken by different states varied substantially depending on the unique characteristics of the state’s insurance market, the history and management of the state’s Blue Cross plan, differences in state law, and other factors, but the NAIC committee was helpful to all states.

Similarly, a task force or working group that would study the proposed Aetna-Humana and Anthem-Cigna mergers would be helpful to all states. It would appear that in the majority of states at least one of the proposed mergers would have presumptively anticompetitive effects, and that in a substantial minority of states both mergers are likely to have anticompetitive effects. On the other hand, in some states, neither merger may present a direct competitive problem. So, while the effect of the merger will differ in each state, and each state should certainly make its own decision on the merger, an NAIC task force or working group on the mergers could study issues that are common to all states, and its analysis could be helpful to all states.

I thank the NAIC and Chairman Sevigny for accepting this submission and for granting me an opportunity to present before the Health Insurance and Managed Care (B) Committee.

¹⁰⁴ Ben Nelson, *About the NAIC*, NAIC.org, <http://goo.gl/eWiJDB> (last visited Nov. 15, 2015).

¹⁰⁵ See *Health Insurance and Managed Care (B) Committee*, NAIC.ORG, <http://goo.gl/ndLHTZ> (last visited Nov. 15, 2015).

¹⁰⁶ State attorneys generals regularly form these types of committees to investigate mergers that impact several states.

¹⁰⁷ *Id.* (listing task forces and working groups).

Appendix A: Insurance Commissioner Reviews of Health Insurance Mergers

The following provides a summary of selected merger cases reviewed by Insurance Commissioners from a number of states.¹ In each of these matters, an Insurance Commissioner either blocked the insurance merger outright, ordered divestitures, or required the parties implement regulatory remedies.

| Matter | Outcome |
|---|--|
| <p><i>Blue Cross and Blue Shield of Montana & Health Care Services Corp.</i> <u>Montana—2013</u></p> <p>At the time of the merger, Health Care Services Corporation (“HCSC”) was the fourth largest insurer in the United States and hoped to acquire Blue Cross and Blue Shield of Montana’s business, including 250,000 Blue Cross customers within Montana.</p> | <p>The Montana Insurance Commissioner approved the deal, but required a number of conditions:</p> <ul style="list-style-type: none"> • HCSC must establish a customer service center and create 100 jobs in Montana by the end of 2016. • HCSC must charge Montana Blue Cross subscribers lower administrative fees than Montana Blue Cross. • \$40 million payment to a new foundation, which will spend the money to support the public interest in Montana. • Must publicly report the salaries of HCSC Montana executives. <p>See: http://goo.gl/KTXWWi</p> |
| <p><i>Highmark, Inc. & Independence Blue Cross Pennsylvania</i> <u>Pennsylvania—2009</u></p> <p>The merger between Highmark and Independence Blue Cross (“IBC”) would have created an entity with 51 percent market share throughout the Commonwealth of Pennsylvania. The Department of Justice, Antitrust Division, approved the mergers in two separate investigations in 2007 and 2008.² The Pennsylvania Insurance Commissioner opposed the merger.</p> | <p>For two years, the Insurance Commissioner held public hearings gathering over 50,000 pages of documents and economic reports studying how the mergers would impact the Pennsylvania health insurance marketplace. The Commissioner offered the following findings regarding the transaction:</p> <ul style="list-style-type: none"> • The merger would have lessened competition and disadvantaged providers resulting in fewer choices for consumers and weaker provider networks. • There was nearly \$1 billion in efficiencies that could have been |

¹ This list does not include all merger reviewed by insurance commissioners.

² Rick Stouffer, *Justice department clears Highmark-IBC merger, again*, TRIBLIVE (July 17, 2008), <http://goo.gl/ncAEet>.

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| | <p>achieved by the merger, but these efficiencies did not nearly outweigh the anticompetitive harms.³</p> <p>After a lengthy, public review process, Highmark and IBC called off the merger.</p> <p>See: http://goo.gl/Jt6yYT</p> |
| <p><i>UnitedHealth Group, Inc. & Sierra Health Services, Inc.</i> <u>Nevada—2008</u></p> <p>The merger combined UnitedHealth with the largest insurer in Nevada, Sierra. While the Department of Justice filed a complaint and subsequent consent decree requiring the parties divest Medicare Advantage plans in Las Vegas, the Nevada Insurance Commissioner examined a range of other competition issues in other product markets.</p> | <p>Ultimately the merger was approved, but the Nevada Insurance Commissioner required the parties make the following commitments/conditions to operations in Nevada:</p> <ul style="list-style-type: none"> • No acquisition costs will be passed along to health care consumers or providers. • No premium increases as a result of the costs of the acquisition. • Sierra will maintain its claim handling system post-merger. • No scaling back of benefit plans. • United will take specific actions to reduce the number of uninsured Nevadans. <p>See: http://goo.gl/qSahRb</p> |
| <p><i>UnitedHealth Group, Inc. & PacifiCare Health Systems, Inc.</i> <u>California—2005</u></p> <p>The merger combined UnitedHealth with PacifiCare. United had a large national presence while PacifiCare was predominantly an insurer operating in the western part of the United States. After an extensive review, the Department of Justice filed a lawsuit to block the transaction and offered a consent decree requiring the parties divest commercial insurance plans in Tucson, Arizona and Boulder, Colorado. The parties consented to the DOJ's terms. The California Insurance Commissioner extracted further remedies.</p> | <p>While the merger was approved in California, the Insurance Commissioner required the following remedies from the parties:</p> <ul style="list-style-type: none"> • Parties must pay \$250 million for health care to underserved communities. • Pay an additional \$13.7 million to physicians for quality improvements. • For four years, United could not fund any dividend with profits from PacifiCare's health insurance operations in California. • Guarantee that customer services remain unaffected. • Parties could not pass the costs of the deal along to their enrollees. |

³ See Press release, Joel Ario on Highmark and IBC Consolidation (Jan. 22, 2009).

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| <p><i>Anthem Inc. & WellPoint Health Networks, Inc.</i> <u>Georgia—2004</u></p> <p>The combination of Anthem and WellPoint combined two Blue Cross licensees and formed the largest managed care insurance company in the country. The Department of Justice took no action in this matter.</p> | <p>See: http://goo.gl/WDdLtJ</p> <p>While approving the merger, the Georgia Insurance Commissioner was able to obtain significant financial contributions for his state as well as other remedies:</p> <ul style="list-style-type: none"> • The total value of the remedy was \$126.5 million including \$100 million dedicated to investment in Georgia health care facility expansion. • The parties must fund staffing and equipment for the state’s telemedicine network. • A commitment to not raise premiums post-merger. <p>See: http://goo.gl/n5fZwO</p> |
| <p><i>Anthem, Inc. & WellPoint Health Networks, Inc.</i> <u>California—2004</u></p> <p>The same insurance merger reviewed by the Georgia Insurance Commissioner (above). The combination of Anthem and WellPoint combined two Blue Cross licenses and formed the largest managed care insurance company in the country. The Department of Justice took no action in this matter.</p> | <p>In California, the Insurance Commissioner originally disapproved of the merger, leading to Anthem and WellPoint filing suit against the Commissioner.⁴ However, the Commissioner eventually approved the merger subject to the following conditions:</p> <ul style="list-style-type: none"> • Anthem pay \$265 million for various California health projects, including \$100 million to the Investment in a Health California Program. • Anthem agreed to work with the state to improve its programs for a number of diseases. • A written agreement from the parties that, post-merger, they would not increase premiums to former WellPoint policy holders. <p>See: http://goo.gl/IG1X4c</p> |
| <p><i>CareFirst, Inc. & WellPoint Health Networks, Inc.</i> <u>Maryland—2003</u></p> <p>CareFirst, an independent non-profit operating along the east coast, attempted to merge with WellPoint, a significant for-profit insurer. As part of the process, CareFirst</p> | <p>The Maryland Insurance Commissioner reviewed both the conversion of CareFirst to for-profit status as well as the merger with WellPoint. After 100 hours of testimony and 85,000 pages of documents were reviewed, the Commissioner concluded that the “deal is bad for the public.” In blocking the deal, the Commissioner found:</p> |

⁴ *Anthem Files Lawsuit Against California Insurance Commissioner*, PR NEWSWIRE (Aug. 3, 2004), <http://goo.gl/KBrgrtd>.

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| <p>would convert and become a for-profit insurer in Maryland.</p> | <ul style="list-style-type: none"> • Appropriate steps were not taken to ensure that CareFirst officers did not receive remuneration as a result of the merger. • CareFirst did not exercise due diligence in deciding to engage in the acquisition, in selecting the transferee, and in negotiating the terms and conditions of the acquisition. • The merger could create a significant adverse effect on the availability or accessibility of health care services in Maryland. • The merger was not equitable to CareFirst insureds. <p>See: http://goo.gl/5qEa04</p> |
| <p><i>Anthem Inc. & Blue Cross Blue Shield of Kansas</i> <u>Kansas—2003</u></p> <p>The merger would have combined Anthem with Blue Cross Blue Shield of Kansas, the largest health insurer in the state with 715,000 enrollees in 2003.</p> | <p>The Kansas Insurance Commissioner issued an order rejecting the merger, arguing that it would not benefit policyholders or the general public. The merging parties appealed the Commissioner’s decision to the Kansas Supreme Court who upheld the Insurance Commissioner’s order.⁵ In particular, the Kansas Supreme Court noted that it was well within the broad authority of the Commissioner to deny acquisitions.</p> <p>See: http://goo.gl/zlfV8S</p> |
| <p><i>Excellus & Univera</i> <u>New York—2001</u></p> <p>The merger combined two upstate New York health insurance companies spanning coverage from Rochester, NY to Buffalo, NY.</p> | <p>The Superintendent of Insurance of New York approved the merger with conditions to safeguard insurance consumers. A critical piece of the safeguards was the requirement that the parties create a charitable foundation into which certain assets of the Univera companies were contributed. The initial contributions would be used to fund charitable purposes to improve the health status of citizens in Univera’s service areas.</p> <p>See: http://goo.gl/VIhfCm</p> |

⁵ *Praeger v. Blue Cross and Blue Shield of Kansas, Inc.*, 75 P.3d 226, (Kan. 2003)

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| <p><i>Harvard Pilgrim Health Care & Matthew Thornton</i> <u>New Hampshire—1996</u></p> <p>Harvard Pilgrim, operator of the largest health maintenance organization (“HMO”) plan in New Hampshire, sought to acquire Matthew Thornton, another HMO operating within the state.</p> | <p>The New Hampshire Insurance Department consented to the acquisition but required a number of conditions:</p> <ul style="list-style-type: none"> • The parties could not enter into an exclusive arrangement with a physician group in Concord, New Hampshire. • The parties would have to contribute \$15 million to the New Hampshire health care transition fund, and an additional \$20 million for activities designed to benefit the state’s health care consumers.⁶ <p>However, due to the intervention by New Hampshire Department of Insurance, the parties called off the merger.</p> <p>See: http://goo.gl/lvbQOQ</p> |
| <p><i>United HealthCare Co. & MetraHealth Companies, Inc.</i> <u>Missouri—1995</u></p> <p>The acquisition involved United Healthcare acquiring MetraHealth. The merger would involve all of Metra’s businesses, including MetLife St. Louis HMO.</p> | <p>The Missouri Department of Insurance filed suit and the parties agreed to a consent decree. The Missouri Department of Insurance allowed the merger to move forward but required that United Healthcare divest MetLife St. Louis HMO due to concerns that the merger would lessen competition in St. Louis for “insured managed care.”⁷</p> |
| <p><i>Blue Cross Blue Shield of Missouri & HealthLink</i> <u>Missouri—1995</u></p> <p>Blue Cross Blue Shield of Missouri sought to acquire HealthLink, the operator of a large preferred provider organization (“PPO”) program for self-insured employers and for other insurers or payors who sought to rent a network. HealthLink also owned a small start-up HMO.</p> | <p>The Missouri Department of Insurance, after review of the HMO portion of the acquisition, approved it subject to the following conditions:</p> <ul style="list-style-type: none"> • From September 1, 1995 through August 31, 1996, the combined entities could not increase premium rates cells or rate formularies for HMO and PPO products for certain group customers within St. Louis Metropolitan Statistical Area. • For renewing groups, the cumulative percentage change could not increase by more than 90% of the sum of the |

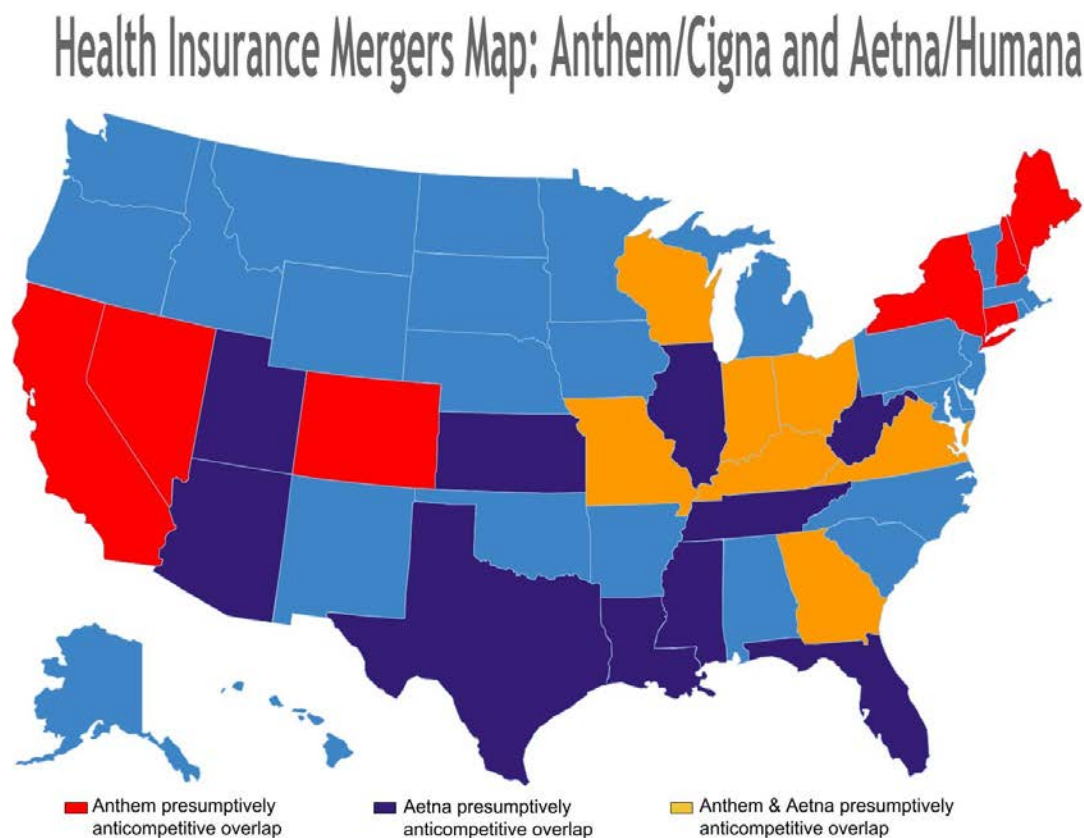
⁶ *In re Matthew Thornton Health Plan* (N.H. Ins. Dept. Jan. 12, 1996).

⁷ *In re Proposed Acquisition of MetLife HealthCare Network, Inc.*, Case No. 95-07-13-0006 (Mo. Dept. of Ins. Sept. 28, 1995).

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| | <p>consumer price index (“CPI”) for 2 years (through August 1997).</p> <ul style="list-style-type: none"> • HealthLink’s guarantee that its employer fees for self-insured programs would not increase at rate in excess of the annual percentage increase in non-medical CPI. • For two years, the combined entities would not enter into any new contract with a hospital or hospital network in the St. Louis area that contained any provision by which the hospital or hospital network agreed to lower rates to the new combined entities or HealthLink to a rate lower than those provided by the hospital or network to another payor. <p>See: https://goo.gl/WCxGD9</p> |
| <p><i>United HealthCare Corporation & GenCare Health Systems, Inc.</i> <u>Missouri—1994</u></p> <p>At the time of the merger, GenCare was the largest health plan in St. Louis, and United owned the 128,000 member Physicians Health Plan of Greater St. Louis.</p> | <p>The Missouri Department of Insurance approved United’s acquisition subject to the following conditions:</p> <ul style="list-style-type: none"> • United and GenCare would not increase premiums for new group customers for a two year period. • For two years, coverage renewals by United and GenCare would not increase annual renewal premium rates by more than 90% of increase in medical component of the CPI. • For the same two year period, any change in rates would not exceed 10%. <p>See: http://goo.gl/zbRUDS</p> |

Appendix B: Overlaps from Anthem-Cigna and Aetna-Humana Mergers

Below is a map of states that, based on *current, available information*, face presumptively anticompetitive overlaps from the mergers of Anthem-Cigna and Aetna-Humana. The merger overlaps occur in a number of health insurance products, including individual and small group plans, fully-insured employer plans, self-insured employer plans, and Medicare Advantage plans.¹ The map was created from data and testimony offered by a number of different sources.² The sources analyzed the mergers of Anthem-Cigna and Aetna-Humana and their competitive overlaps using concentration figures calculated by the Herfindahl-Hirschman Index and by market share data based on number of beneficiaries.



¹ The map does not analyze competitive overlaps or loss of competition on the Insurance Exchanges.

² Sources are as follows. Gretchen Jacobsen, Anthony Damico, & Tricia Neuman, *Data Note: Medicare Advantage Enrollment, by Firm, 2015*, KAISER FAMILY FOUNDATION (July 14, 2015), <http://goo.gl/g1rJ0Z>; see also Market Share and Enrollment of Largest Three Insurers- Individual Market, 2013, KAISER FAMILY FOUNDATION (2015), available at <http://goo.gl/T4jgL7>; see also *Effects on Competition of Proposed Health Insurer Mergers: Hearing before Comm. on the Judiciary Subcomm. on Regulatory Reform, Commercial and Antitrust Law*, 114th Cong. 5-8 (Sept. 29, 2015) (testimony of Edmund F. Haislmaier, Heritage Foundation), available at <http://goo.gl/9E2Dkm>; see also *Effects on Competition of Proposed Health Insurer Mergers: Hearing before Comm. on the Judiciary Subcomm. on Regulatory Reform, Commercial and Antitrust Law*, 114th Cong. 3 (Sept. 29, 2015) (testimony of Tom Nickels, Vice President, Am. Hospital Assoc.); see also Press Release, Am. Med. Assoc., AMA Releases Analyses on Potential Anthem-Cigna and Aetna-Humana Mergers (Sept. 8, 2015), available at <http://goo.gl/3TZoJn>.

Appendix C: Important Sources for the Anthem-Cigna and Aetna-Humana Mergers

The following list contains ten of the most important sources that both the National Association of Insurance Commissioners and Insurance Commissioners should review when analyzing the mergers of Anthem-Cigna and Aetna-Humana. The list contains testimony from the merging parties, testimony from opponents and objective third parties, economic studies on health insurance mergers, and scholarly articles.

(1) *Effects on Competition of Proposed Health Insurer Mergers: Hearing before Comm. on the Judiciary Subcomm. on Regulatory Reform, Commercial and Antitrust Law*, 114th Cong. (Sept. 29, 2015) (testimony of Joseph Swedish, President & CEO of Anthem, Inc.), available at <http://goo.gl/UoPssD>.

(2) *Effects on Competition of Proposed Health Insurer Mergers: Hearing before Comm. on the Judiciary Subcomm. on Regulatory Reform, Commercial and Antitrust Law*, 114th Cong. (Sept. 29, 2015) (testimony of Mark T. Bertolini, Chairman & CEO of Aetna, Inc.), available at <http://goo.gl/TokebO>.

(3) *Effects on Competition of Proposed Health Insurer Mergers: Hearing before Comm. on the Judiciary Subcomm. on Regulatory Reform, Commercial and Antitrust Law*, 114th Cong. (Sept. 29, 2015) (testimony of Tom Nickels, Vice President, Am. Hospital Assoc.), available at <http://goo.gl/KIR4y9>.

(4) Letter from James L. Madara, Executive V.P. & CEO of Am. Med. Assoc., to William Baer, Assistant Attorney General, U.S. Dep't of Justice (Nov. 11, 2015), available at <http://goo.gl/en6Dtl>.

(5) *Effects on Competition of Proposed Health Insurer Mergers: Hearing before Comm. on the Judiciary Subcomm. on Regulatory Reform, Commercial and Antitrust Law*, 114th Cong. (Sept. 29, 2015) (testimony of Edmund F. Haislmaier, Heritage Foundation), available at <http://goo.gl/9E2Dkm>.

(6) Leemore Dafny, Mark Duggan, & Subramaniam Ramanarayanan, *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, 102 AM. ECON. REV. 1161 (2012), available at <http://goo.gl/4NV9bI>.

(7) José R. Guardado, David W. Emmons, & Carol K. Kane, *The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra*, 1 Health Mgmt., Pol'y & Innovation (2013), available at <http://goo.gl/GQqffg>.

(8) Dana Polsky & Janet Weiner, *State Variation in Narrow Networks on the ACA Marketplaces*, LEONARD DAVIS INST. OF HEALTH ECON. (Aug. 2015), available at <http://goo.gl/kkCWAT>.

(9) David Balto and James Kovacs, *Health Insurance Merger Frenzy: Why DOJ Must Just Say 'No'*, LAW360 (Aug. 17, 2015 5:59 PM), <http://goo.gl/vOQh9z>.

(10) Thomas Greaney, *Examining Implications of Health Insurance Mergers*, HEALTH AFFS. (July 16, 2015), <http://goo.gl/ETT1DB>.