

May 10, 2016

Joel H. Peck  
Clerk of the State Corporation Commission  
Document Control Center  
P.O. Box 2118  
Richmond, VA 23218-2118

Re: Case No. INS-2015-00154

Dear Clerk Peck:

On behalf of the Virginia Hospital & Healthcare Association (VHHA) and its 30 member health systems, with 107 community, psychiatric, rehabilitation and specialty hospitals, we appreciate the opportunity to submit these written comments expressing our concerns regarding the proposed health insurance combination between Anthem, Inc. and Cigna Corporation and its subsidiaries. For the reasons detailed below, this combination would likely have consequences that are detrimental to policyholders and the general public. Given the size and scope of these proposed mergers, the transactions will substantially reduce competition, likely increase the costs of premiums and diminish the insurers' willingness to be innovative partners with providers and consumers in transforming care. Accordingly, we urge the Commission to deny the application.

### **Excessive insurer market concentration in Virginia**

Anthem already has significant concentration in the self-insured and fully-insured commercial markets in Virginia, which the Cigna acquisition would multiply. In fact, review of market concentration data previously made available to the Commissioner of Insurance demonstrates that Virginia is in the top tier of states in terms of the anti-competitive effects of the Anthem-Cigna combination. Under federal antitrust guidelines, market concentration is measured by the Herfindahl-Hirschman Index (HHI). The guidelines generally consider markets with an HHI in excess of 2,500 to be highly concentrated and set a threshold for additional scrutiny for transactions that increase the HHI by more than 200 points in such markets.

Outside of Northern Virginia (where Anthem has a non-compete arrangement with its Blues affiliate CareFirst), every MSA in the Commonwealth already has HHIs well in excess of 2,500 and the Anthem-Cigna transaction would increase market concentration by far more than 200. For example, the impact in the Richmond market is more than 8 times this threshold. High levels of insurance concentration in exchange markets are already correlated with higher premiums and will only worsen if this transaction moves forward.<sup>1</sup> These excessive levels of market concentration are also likely to be sustained long term given the high barriers to entry associated with the insurance marketplace.

The parties may very well argue for evaluating the market for insurance purposes in a variety of subcomponents by product type when it comes to the regulatory review process for the desired combination. However, from the health care provider perspective, the existence of slightly different benefit plan structures for the consumer is irrelevant since Anthem typically adopts a policy of “all products” for provider contracts. Participation in one product type mandates participation in all other product types, so the existence of these variations does not diminish the adverse effects of high market concentration.

The likely consequences of ever greater insurance market concentration for providers is the risk of monopsony purchasing power that could drive prices and access to services below competitive levels without providing any offsetting benefit to consumers. Given the dominant market share in most Virginia markets, individual health systems and providers will have little choice but to contract with the combined carrier. Anthem has demonstrated a propensity to act in a unilateral manner to implement provider network and benefit plan changes (*e.g.*, most recently by eliminating some sites-of-service for highly complex infusion services on grounds of medical necessity) that are disruptive to patient care and limit patient choice. Its heavy-handed negotiating tactics with health care providers often leave no alternative besides termination or non-participation in provider networks, posing a legitimate threat to consumer access and choice. There is every reason to believe that these practices will increase with further consolidation.

The parties seeking authority to move forward with this combination will assert that further consolidation will benefit consumers through lower premiums and out-of-pocket costs. Unfortunately for consumers, the research clearly shows that premiums are actually higher in markets with fewer insurers.<sup>2</sup> As one prominent economist has noted, “if past is prologue, insurance consolidation will tend to lower payments to health care providers, but those lower payments will not be passed on to consumers. On the contrary, consumers can expect higher insurance premiums.”<sup>3</sup> This history on insurance consolidation contrasts with the evidence of a downturn in overall health care costs and hospital price trends, together with quality improvements, that have coincided with provider integration (see below).

Additionally, the unique nature of the Blue Cross Blue Shield Association and its negative impact on insurance choices in the Commonwealth will carry over into Cigna’s covered population if the proposed combination is allowed to proceed. As noted previously, Anthem does not compete with their Blues affiliate Care First in Northern Virginia. This is because Blues plans, including Anthem, belong to the Blue Cross and Blue Shield Association, which obligates its members to cede its insured lives to the resident Blue plan for purposes of contracts with providers.<sup>4</sup> As a result, absent a change in this business arrangement, Cigna’s covered population will be added to already existing plans that are subject to these market restraints and lessen competition in every region of the Commonwealth.

### **Current rate review and MLR requirements are insufficient to assure consumers benefit**

Finally, the parties may argue that current rate monitoring and minimum medical loss ratio (MLR) requirements function to limit the ability of plans to exercise market power regardless of market concentration. There is no evidence to support this assertion and two primary factors limit the effectiveness of MLR requirements in controlling costs. First, MLR requirements don’t apply to the majority of covered lives as self-insured plans are exempt. Second, total premium amounts are not constrained, just the proportion of income that applies to “qualified” medical

expenses.<sup>5</sup> In short, this is an insufficient mechanism to ensure that any savings from consolidation will produce benefits for consumers through lower premiums or out-of-pocket costs.

### **Further insurer consolidation likely to lessen support for critical health care innovations**

National payers often have less incentive or inclination to participate or invest resources in Virginia-specific payment and delivery system innovations. There is no evidence in the literature to support the assertion that insurer consolidation yields greater innovation in product design or payment practices. In fact, the evidence more often suggests that consolidation leads to premium increases, less product innovation and less generous benefits for consumers.<sup>6</sup>

Anthem's history in the Commonwealth demonstrates a consistent pattern of strong reluctance and often an unwillingness to participate in multi-payer payment reform or quality improvement initiatives. Whether it is a matter of supporting system-wide value improvement tools such as the statewide Health Information Exchange or an All Payer Claims Database, Anthem's response has more often than not been one of resistance. And, unlike Anthem's approach in other states and the practices of other carriers (including Cigna), their business practices in the Commonwealth reflect an unwillingness to enter into or even explore contracts for innovative provider arrangements such as clinically integrated networks designed to achieve both cost and quality improvement targets.

There is no evidence in Virginia's history, or in other markets, to indicate that allowing an already dominant insurer to gain greater market share and become even more protected against competitive pressures will result in a greater willingness to accelerate such innovation or engage in greater collaboration with health care providers or other Virginia stakeholders in an effort to improve overall value and quality in health care.

### **Goals and Results from health system integration are very different than payer consolidation**

To be sure, significant changes in the organization and delivery of care are well underway in the Commonwealth. The primary purpose of health system integration is to transform health care delivery to improve overall health, achieve optimal quality and health outcomes, and lower overall health care costs.

Health system integration requires reshaping the delivery system to bridge care silos, coordinate care over time and settings, elevate quality and reliability, remain highly responsive to individual patient and family needs and address underlying population health needs. Health systems are investing in the people, practice innovations and information technology systems required to lower readmissions, make major strides in (rigorously measured) patient quality, experiment with accountable care organizations (ACOs) and bundled payment programs, and build high-performing primary care medical homes and teams, among other similar initiatives.

Health systems have partnered with struggling rural hospitals to preserve access to essential services, provide needed capital, upgrade IT systems and introduce operational efficiencies. They

have also subsidized much needed medical expertise and services to ensure the full range of necessary services are available to the communities they serve.

Health systems are pursuing this integration in multiple ways and under multiple organizational structures. But they are doing so even though payers are insisting on their own unique quality and performance measures. Large incumbent payers such as Anthem have consistently demonstrated a strong reluctance, and often unwillingness, to collaborate on common quality improvement priority definitions, provide significant shared risk incentives or support more robust Health Information Exchange, among other similar initiatives. As discussed above, this uncooperative behavior can be expected to only increase if the proposed combination is allowed to proceed.

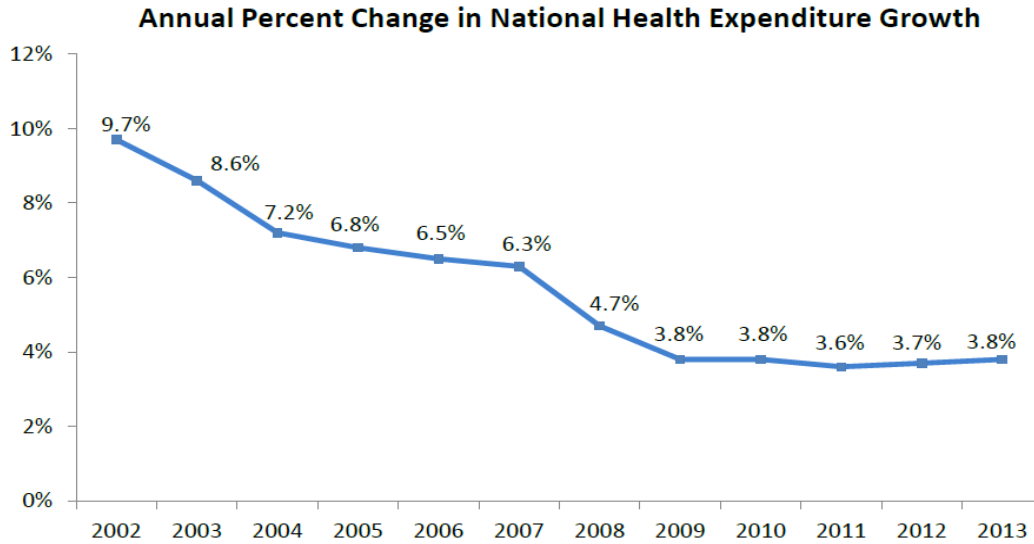
Although the health system and provider integration journey is still underway and the pursuit of excellence in service to patients and communities among health care professional teams and systems must be ongoing and continuous, notable progress has been made on both quality and costs.

With regard to quality and safety, collaborative efforts among Virginia health systems and other stakeholders has achieved notable successes, for example:

- A joint effort involving efforts involving all Virginia hospitals providing obstetric services, the Medical Society of Virginia, the March of Dimes, the Virginia Department of Health and the Virginia Chapter of the American College of Obstetrics and Gynecologists has dramatically lowered the statewide rate of non-medically indicated early elective deliveries – from 4.8% in January 2013 to 1% in 2015.
- Similarly, the statewide rate of Central Line Associated Blood Stream Infections (CLABSI) was nearly cut in half between 2012 and 2015 thanks to collaborative improvement efforts involving Virginia hospitals, the Virginia Department of Health and the VHQC.
- Finally, a variety of hospital based initiatives - such as creation of disease-specific transition clinics, designation of transition-specific staff to enhance support provided to discharged patients and stronger engagement with post-acute providers and community based support organizations – have begun to lower the all-payer readmission rates for cardiac-related conditions.

In fact, all of the consensus quality and service metrics that VHHA and its members track and publicly report on are moving in the right direction.<sup>7</sup> Progress is clearly being made on the quality, safety and service dimensions of provider performance and Virginia hospitals remain committed to accelerating this improvement further.

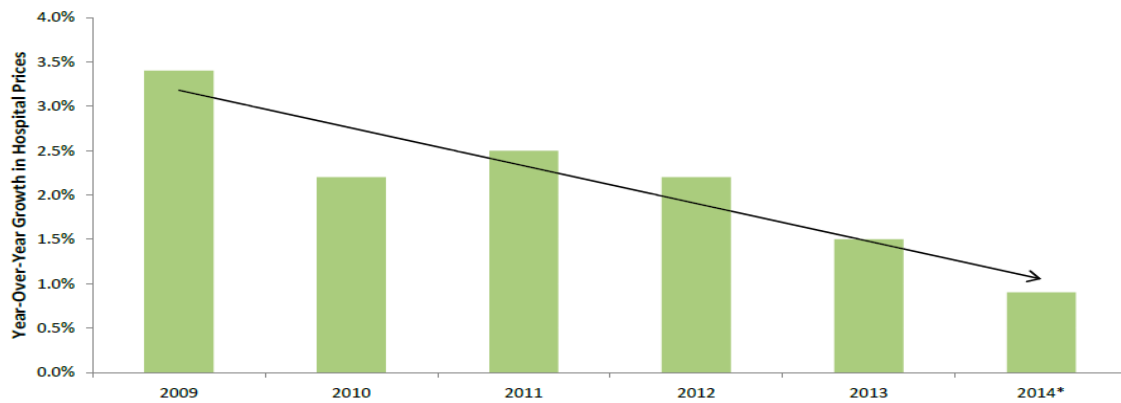
Regarding costs, this period of major restructuring among providers has coincided with historic lows in overall health care spending trends.



Source: Centers for Medicare & Medicaid Services (CMS), Office of the Actuary (OACT) National Health Statistics Group.  
 Note: 2013 is a projection.

Similarly, we have witnessed persistent declines in hospital price increases.

- **Hospital prices increased at an annual rate of 0.9% from December 2013 to June 2014**



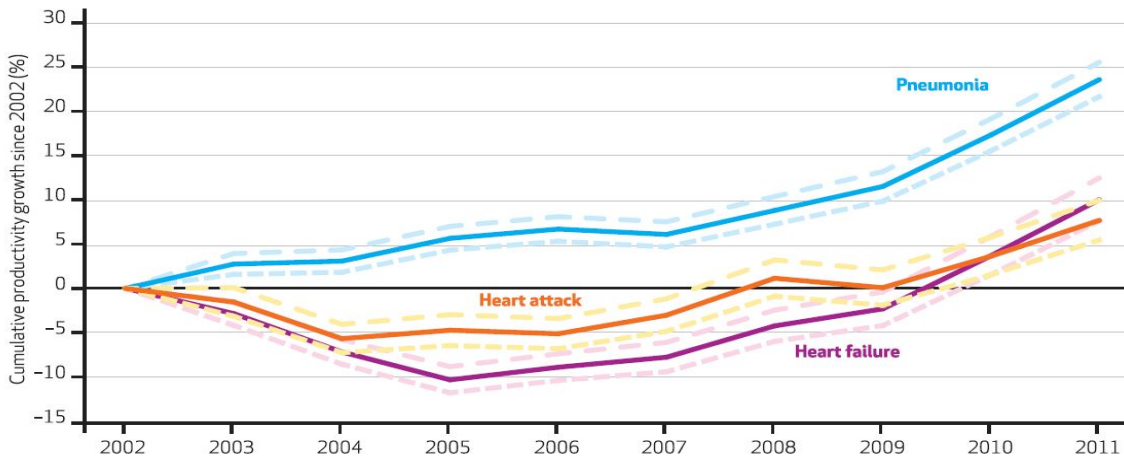
Source: Dobson | DaVanzo analysis of Bureau of Labor Statistics data.  
 Note: Annual growth rates calculated from December to December of each year.\*2014 growth rate calculated from December 2013 to June 2014.

The most recent estimate of national health expenditure trends through 2014 noted that spending did increase 5.3% in that year. However, the analysis found that this uptick was driven by expanding coverage (although much less so in Virginia) and higher drug costs, which together overcame a further “deceleration in overall prices for personal health care services, such as for hospital care and other professional services.”<sup>8</sup>

Finally, hospital productivity growth has also accelerated along with intensity of care provided.<sup>9</sup>

**EXHIBIT 3**

**Cumulative Year-By-Year Hospital Productivity Growth For Three Principal Diagnoses, 2002-11, Relative To 2002**



**SOURCE** Authors' calculations based on data from the Medicare Provider Analysis and Review File (see Note 15 in text). **NOTE** Lighter shaded dashed lines indicate 95 percent confidence intervals.

To summarize, the last 10 years of provider integration is showing evidence of demonstrable improvements in quality and safety, lower overall health care cost trends, improvements in hospital productivity and deceleration in hospital prices. All using publicly reported and transparent metrics that apply to the provider sector.

Comparatively, payer consolidation is motivated primarily by scale and price. And the evidence on benefits to the consumer is hard to discern. In fact, the prevailing evidence associates insurer consolidation with higher premiums.

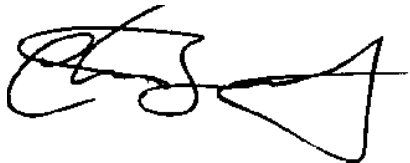
## Conclusion

Anthem's market concentration is already well in excess of competitive levels and will multiply if the proposed combination with Cigna is allowed to proceed, bringing with it a series of adverse consequences for policyholders and the general public. The effect on health care providers in Virginia could be profound, limiting consumer access and choice and stifling needed innovation for transformation of our health care delivery system. In the end, incentive alignment and collaboration across sectors are of utmost importance when it comes to accelerating innovations and pursuing the triple aim of better care, better health and lower costs. Based upon previous experience in Virginia, the proposed combination will run counter to these goals.

There is little evidence that Anthem has been seriously engaged or invested in this work of incentive alignment and system reform in Virginia. At the same time, there is abundant evidence to suggest that further consolidation will be harmful to competition and result in higher costs to consumers.

It is for these reasons we join with consumer and other provider organizations to oppose the proposed combination of Anthem and Cigna in Virginia. We appreciate the opportunity to submit these written comments and look forward to participating in the public hearing on May 25.<sup>th</sup> In the meantime if we can provide any additional information about the issues we have raised we would be happy to do so.

Sincerely,



Christopher S. Bailey, Executive Vice President

cc: Jacqueline L. Cunningham, Commissioner of Insurance

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<sup>1</sup> Eugene Wang & Grace Gee, *Larger Issuers, Larger Premium Increases: Health Insurance Issuer Competition Post-ACA*, TECH. SCI., Aug. 11, 2015, at 11-14, available at <http://techscience.org/a/2015081104/>

<sup>2</sup> Leemore S. Dafny, *Evaluating the impact of health insurance industry consolidation: learning from experience*, Commonwealth Fund, Issue Brief, November 2015, available at [www.commonwealthfund.org/~media/files/publications/issue-brief/2015/nov/1845\\_dafny\\_impact\\_hlt\\_ins\\_industry\\_consolidation\\_ib.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/nov/1845_dafny_impact_hlt_ins_industry_consolidation_ib.pdf).

<sup>3</sup> Testimony of Leemore S. Dafny, Ph.D, Professor of Strategy and Herman Smith Professor of Hospital and Health Services, Kellogg School of Management, Northwestern University before the Senate Committee on the Judiciary Subcommittee on Antitrust, Competition Policy and Consumer Rights, September 22, 2015.

<sup>4</sup> Letter from Melinda Reid Hatton, Senior V. P. & General Counsel, American Hospital Association, to the Honorable William Baer, Assistant Attorney General, U.S. Dep't. of Justice Antitrust Division, February 29, 2016.

<sup>5</sup> Letter from Melinda Reid Hatton, Senior V. P. & General Counsel, American Hospital Association, to Ted Nickel, Commissioner, Wisconsin Office of the Commissioner of Insurance and Katherine L. Wade, Assistant Attorney General, U.S. Dep't. of Justice Antitrust Division, February 29, 2016

<sup>6</sup> Dafny, *Supra* note 3.

<sup>7</sup> VHHA Quality Scorecard, available at <http://www.vhha.com/communications/vhha-updates-quality-and-patient-safety-scorecards/>.

<sup>8</sup> Martin et al and the National Health Expenditure Accounts Team, *National Health Spending in 2014: Faster Growth Driven by Coverage Expansion and Prescription Drug Spending*, Health Affairs, Dec. 2, 2015.

<sup>9</sup> Romley et al, *US Hospitals Experience Substantial Productivity Growth During 2002-11*, Health Affairs, February 11, 2015.