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*By Email and Courier*

August 5, 2015

The Honorable William Baer
Assistant Attorney General
United States Department of Justice Antitrust Division
950 Pennsylvania Avenue, N.W.
Washington, D.C., 20530

Dear Assistant Attorney General Baer:

I am writing on behalf of the nearly 5,000 member hospitals, health systems and other health care organizations, and 43,000 individual members of the American Hospital Association (AHA) regarding the proposed acquisitions involving four of the five major commercial health insurance companies in the United States: Anthem's proposed acquisition of Cigna and Aetna's proposed acquisition of Humana. Because the size and scope of these proposed acquisitions is so enormous and their potential anticompetitive impact on access, affordability and innovation is so profound, we will address them in separate letters in the knowledge that the Antitrust Division of the Department of Justice (Department) has indicated it will likely consider them collectively. This letter will focus on the proposed Anthem/Cigna deal.

We endorse the Department's often stated position that reforms in the health insurance industry are dependent on vigorous antitrust enforcement, particularly those involving significant commercial insurers where there is the very real potential for those deals to substantially reduce competition and substantially diminish the insurers' willingness to be innovative partners with providers and consumers in transforming care. We believe the announced deals cited above have that potential and, therefore, merit the closest scrutiny to determine whether remedies, such as divestitures, have any chance of ameliorating the enduring damage they could do as a result of the loss of such significant competition.

While some are comparing these acquisitions to those in the hospital sector, we submit that the antitrust issues for these transactions are fundamentally different. The size, scope and enduring impact of the announced deals far surpass any hospital merger. These transactions will combine four of the five national health insurance companies, with effectively no possibility that existing firms could replicate their size and scope. As the Department has long recognized, there are substantial barriers to entry in the health insurance sector (*United States and the State of*

*Michigan v. Blue Cross Blue Shield of Michigan and Remarks by Sharis A. Pozen on Competition and Health Care: A Prescription for High-Quality Affordable Care, March 19, 2012*). Moreover, the seeming underlying business case for them – increasing "top-line" revenues and profits through acquisition rather than competition without offsetting demonstrable efficiencies – is fundamentally different than that for transactions in the hospital sector. The hospital sector is undergoing profound structural changes, driven by the need to take on risk as the field moves away from fee-for-service payments toward population health, offer integrated clinical care, and provide financially failing facilities with the resources they require to survive and continue to serve their communities. Yet despite those pressures, the growth in hospital spending is at historic lows, which is entirely inconsistent with claims from commercial insurers about the impact of hospital transactions (*Bureau of Labor Statistics Producer Price Index data, 2014-2015, for Hospitals (622)*).

The attached analysis details the competitive issues that the Department will consider as it reviews these deals and the precedents that suggest both are, and should be, at risk. Regulations in the Affordable Care Act, such as the Medical Loss Ratio (MLR), do not warrant scaled-back application of the antitrust laws. A keystone component of that act is competition, and the MLR requirements do nothing to prevent the combined firms from increasing prices or reducing competition in service, quality, plan design and the like.

We look forward to working with the Department throughout its investigation of these insurance deals. To that end, we will be contacting the Department to request meetings with staff and top officials to more fully discuss our concerns and ways in which we can be of assistance.

For more information, you can contact me directly at mhatton@aha.org or (202) 626-2336.

Sincerely,

/s/

Melinda Reid Hatton
Senior Vice President & General Counsel

***Attachment***

**Detailed Analysis of the American Hospital Association**

On behalf of the nearly 5,000 members of the American Hospital Association (AHA), we urge that the Antitrust Division of the Department of Justice (Department) thoroughly investigate Anthem, Inc.'s (Anthem) planned $54 billion acquisition of Cigna Corporation. There is a material risk that the transaction is likely to substantially reduce competition, in violation of Section 7 of the Clayton Act.[1] The potential harm to consumers from this loss of competition is large and durable. Because the two companies generate more than $100 billion in combined revenues, even a modest price increase would cost consumers billions of dollars in higher health care costs.

The geographic breadth of the transaction's potential anticompetitive effects and the number of consumers at risk are also sweeping. The transaction threatens to reduce competition in the sale of commercial health insurance in at least 817 relevant geographic markets, defined as Metropolitan Statistical Areas (MSAs) or rural counties. In 600 of these markets, the transaction would result in a Herfindahl-Hirschman Index (HHI) in excess of 2,500 and a greater than 200-point HHI increase, which under the Department's and the Federal Trade Commission's (FTC) Horizontal Merger Guidelines (Merger Guidelines, or Guidelines) are market concentration levels and increases that the Department "presume[s] to be likely to enhance market power."[2] In an additional 217 markets, the transaction would result in a post-merger HHI in excess of 2,500 and a 100-200 point HHI increase, which the Guidelines say "potentially raise[s] significant competitive concerns."[3] In these 817 at-risk markets the parties collectively serve 45 *million* consumers.

The risk of harm to these tens of millions of consumers is further enhanced because new entry is unlikely to prevent, or even partially offset, the transaction's potential anticompetitive effects. The Department has repeatedly stated in its court filings and in statements by the Department's leadership that there are substantial barriers to entry in the health insurance sector, including obtaining the necessary scale to form a full-service, cost-competitive provider network. As former Acting Assistant Attorney General Sharis Pozen explained, the Department "undertook an extensive review of entry and expansion in the health insurance industry" in 2011, and found that entry in the health insurance sector was often difficult, particularly in already concentrated markets, as is the case in many of the markets at issue here.[4]

The parties will no doubt argue that the transaction would produce offsetting efficiencies, but this is not likely. And it is even less likely that the combined companies would "pass through" any cost savings to consumers. As numerous economists have found, demand for health

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1 15 U.S.C. § 18.

2 *Merger Guidelines* § 5.3.

3 *Id.*

4 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.

insurance is inelastic,[5] which reduces the incentive for large health insurance companies to pass through cost savings. The incentives to pass savings on to consumers are further reduced due to the opaqueness of the insurance markets and the fact that costs and benefits are not fully internalized by consumers.

Anthem and Cigna also will undoubtedly urge that the Department approve the merger after the parties agree to divestitures. It is far from clear that the parties could ever put forth a divestiture package that would reduce the transaction's likely anticompetitive effects. First, the Department has been rightly concerned that the acquirer of any divested lives be well-positioned to compete effectively in the local area. An existing presence in the market can often facilitate the success of a buyer. Accordingly, we have examined to what extent it is possible to eliminate the potentially anticompetitive overlaps through sales to an existing competitor without causing an increase in market concentration. Significantly, in the 817 at-risk markets, over half of the lives that need to be divested reside across 368 MSAs and rural counties with no divestiture possibility that is likely to preserve the pre-merger market structure.

Second, even if the parties somehow managed to maintain the structural status quo, the Department also must require, as it has in its recent enforcement actions, Anthem and Cigna to ensure that the buyers of any divested contracts have a *provider network of comparable cost and breadth* to that of the parties.[6] Indeed, the Department has repeatedly recognized that in order for a health insurer to compete effectively, it must have a full-service, cost-competitive network of hospitals, physicians, and other health care providers.[7]

Third, the Department also should view any remedy proposal carefully because, regardless of the "fix" the parties ultimately propose, the transaction will inevitably eliminate a national health insurance company. The parties are two of only five national health insurance companies that remain today, and two of the other three (Aetna and Humana) also have entered into a consolidation agreement. Recent enforcement actions suggest that all possible relevant markets must be examined closely, particularly in a transaction of this magnitude, which can be challenged on the basis of reduced competition in a market for national customers.[8] In particular, the Department should carefully investigate how this permanent loss of national competitors would affect competition for contracts with national and large regional employers. Obvious sources of evidence that the Department should analyze are the parties' "bid" files reflecting competition between them for these accounts.

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5 *See* M. Kate Bundorf et al., *Pricing and Welfare in Health Plan Choice* 32 (Stanford Inst. for Economic Policy Research Discussion Paper No. 07-47, 2008), http://www-siepr.stanford.edu/papers/pdf/07-47.pdf; Su Liu & Deborah Chollet, *Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature* ix (Mathematic Policy Research Ref. No. 6203-042, 2006), http://www.mathematica-mpr.com/publications/pdfs/priceincome.pdf.

6 *See* Competitive Impact Statement at 17, *United States v. Blue Cross-Blue Shield of Montana*, No. 11-cv-123-RFC (D. Mont. Nov. 8, 2011).

7 *See id.*

8 *See FTC v. Sysco Corp.,* No. 15-cv-256-APM, 2015 U.S. Dist. LEXIS 83482, at *76–78 (D.D.C. June 23, 2015).

Finally, while the competitive overlap between the parties appears somewhat smaller in the sale of Medicare Advantage plans than in the commercial insurance market, the Department also should investigate carefully the transaction's effect on competition in the Medicare Advantage sector. Starting with the Department's challenge to UnitedHealthcare's acquisition of Sierra Health Services in 2008,[9] the Department (working with the Center for Medicare & Medicaid Services) has scrutinized carefully the effect of consolidation of Medicare Advantage providers in order to preserve the benefits of competition for senior citizens that the program was designed to bring. The Department should continue this policy of protecting competition for the sale of Medicare Advantage plans both in its investigation of the Anthem/Cigna transaction, as well in its investigation of Aetna's proposed acquisition of Humana, which we will address in a separate letter.

## 1. The Parties

### A. Anthem

Anthem is one of the largest health insurance companies in the United States. In 2014, Anthem generated approximately $73 billion in revenues.

Anthem is investor-owned and publicly-traded, and operates plans under the Blue Cross (BCBS) brand in 14 states. The Anthem companies serve members as the Blue Cross licensee for California, and as the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as the Blue Cross Blue Shield licensee in 10 New York City metropolitan and surrounding counties and as the Blue Cross or Blue Cross Blue Shield licensee in selected upstate counties), Ohio, Virginia (excluding the northern Virginia suburbs of Washington, D.C.) and Wisconsin.

Anthem also conducts business through arrangements with other BCBS licensees in South Carolina and Texas; and through its Amerigroup subsidiary in Florida, Georgia, Kansas, Louisiana, Maryland, Nevada, New Jersey, New Mexico, New York, Tennessee, Texas and Washington. The company is licensed to conduct insurance operations in all 50 states through its subsidiaries.

Anthem has been strikingly successful on its own. In 2014, the company grew its membership by 1.8 million new members, including more than 700,000 members from the Public Exchanges, and surpassed 5 million members in its Medicaid business. In 2014 Anthem increased its revenues by nearly $3 billion, or approximately 5 percent over the previous year. Moreover, the company "made and [is] continuing to make substantial investments in new capabilities that better serve [its] members and *will help drive future growth* [and it is] confident that by remaining disciplined, consistent and accountable for delivering results, [it] will achieve [its] goals."[10]

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[9] *See* Complaint, *United States v. UnitedHealth Group Inc.*, No. 08-cv-322 (D.D.C. Feb. 25, 2008).
[10] Anthem, Inc., 2014 Annual Report 9 (2015).

Anthem reported 38.5 million members in its medical plans, as of June 30, 2015. Of these, 5.8 million were in Medicaid plans, 1.4 million in Medicare Advantage, 1.6 million in FEP, and 1.8 million in individual products. Approximately 29 million are commercial group members.[11]

**B. Cigna**

Cigna also is one of the largest health insurance companies in the United States, with 15 million members in all 50 states. In 2014, Cigna generated approximately $35 billion in revenues. Like Anthem, Cigna provides a wide range of commercial plans and has more than 14.2 million commercial members.[12]

Cigna also has been very successful on its own. Cigna's 2014 Annual Report states that in 2014 the company increased revenue by 8 percent and earnings per share by 9 percent last year. And over the last five years, Cigna "delivered compound annual growth of 14 percent for revenues and 14 percent for adjusted income from operations on a per share basis."[13] Moreover, the 2014 Annual Report (which was issued months before the announcement of its transaction with Anthem) states that, on its own, Cigna expected to achieve substantial growth, such as:

- "Growing revenues by eight to ten percent in 2015;
- Doubling the size of [its] business over the next seven to eight years[;] and
- Delivering on [its] long-term Earnings Per Share objective of 10 to 13 percent compound growth on an annual basis."[14]

## 2. The Antitrust Laws Applied to Health Insurance Mergers

As noted in the 2004 report, *Improving Health Care: A Dose of Competition*, the federal antitrust agencies, for decades, have had a bipartisan "commitment to vigorous competition on both price and non-price parameters [ ] in health care."[15] As the Agencies have explained, in this sector "[p]rice competition generally results in lower prices and, thus, broader access to health care products and services. Non-price competition can promote higher quality and encourage innovation."[16]

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[11] Press Release, Anthem, Inc., Anthem Reports Second Quarter 2015 Results (July 29, 2015) http://ir.antheminc.com/phoenix.zhtml?c=130104&p=irol-newsArticle&ID=2072061.

[12] Press Release, Cigna Corp., Cigna Reports Strong Second Quarter 2015 Results, Affirms Increased Outlook (July 30, 2015) http://newsroom.cigna.com/NewsReleases/Cigna-Reports-Strong-Second-Quarter-2015-Results--Affirms-Increased-Outlook.htm.

[13] Cigna Corp., 2014 Annual Report 3 (2015) (footnote omitted).

[14] *Id.*

[15] Dep't of Justice & Federal Trade Comm'n, *Improving Health Care: A Dose of Competition* 29 (July 2004), http://www.justice.gov/sites/default/files/atr/legacy/2006/04/27/204694.pdf.

[16] *Id.* at 4.

The Affordable Care Act (ACA) has not diminished the importance of antitrust enforcement in the commercial health insurance sector. To the contrary, the Department's leadership has made clear that:

> The success of health care reform will depend as much upon healthy competitive markets as it will upon regulatory change. If health care reform is to produce more efficient systems, bring health care costs under control, and provide higher-quality health care delivery, then we must vigorously combat anticompetitive mergers and conduct that harm consumers with responsible antitrust enforcement.[17]

The Department has primary responsibility for enforcing the antitrust laws in the health insurance sector.[18] In this capacity, the Department has challenged transactions that cause a significant increase in market concentration and loss of localized head-to-head competition.[19] In its enforcement actions, the Department has set forth a clear analytical framework for evaluating transactions, which it should apply rigorously in reviewing this transaction of unprecedented size and scope. We summarize that framework and then apply it to the Anthem/Cigna transaction to demonstrate the substantial risk that the transaction presents to competition and consumers.

### A. Relevant Product Market

The Department has consistently recognized that group commercial health insurance is a well-defined antitrust-relevant product market. The Department has explained that, for individuals who obtain commercial health insurance through their employers, there are no reasonable competitive alternatives to group health insurance. This is because the closest alternative—individual health insurance—is typically much more expensive than group health insurance, in part because, while group health insurance is purchased using pre-tax dollars, individual health insurance is not.[20]

The Department also has determined that individual (and relatedly, small group) insurance is a relevant antitrust product market. As the Department has found, "individual health insurance is the only product available to individuals without access to group coverage or

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17 Pozen, *Competition and Health Care* at 19.

18 The FTC conducts the bulk of the antitrust investigations that involve hospitals.

19 *See, e.g.*, Complaint, *United States v. Humana Inc.*, 12-cv-464 (D.D.C., Mar. 27, 2012) (Medicare Advantage); Complaint, *United States v. Blue Cross Blue Shield of Montana*, No. 11-cv-123-RFC (D. Mont. Nov. 8, 2011) (group commercial and individual insurance); Complaint, *United States v. UnitedHealth Group Inc.*, No. 08-cv-322 (D.D.C. Feb. 25, 2008) (Medicare Advantage); Complaint, *United States v. UnitedHealth Group Inc.*, No. 05CV02436 (Dec. 20, 2005) (large group commercial insurance; small group commercial health insurance); Complaint, *United States v. Aetna, Inc.*, No. 99 CV 1398-H (June 21, 1999) (commercial plans.) These enforcement actions reflect the Department's experience in the insurance sector, including its understanding that, unlike many industries, health insurance is characterized by strong and durable barriers to entry. *See* Complaint at ¶ 35, *United States v. Blue Cross Blue Shield of Michigan*, No. 10-cv-14155-DPH-MKM (E.D. Mich. Oct. 18, 2010).

20 *See* Complaint at ¶¶ 21–24, *Blue Cross Blue Shield of Montana*.

government programs that allows them [(1)] to reduce the financial risk of adverse health conditions and [(2)] to have access to health care at the discounted prices negotiated by commercial health insurers." The Department has explained that "[t]here are no reasonable alternatives to individual health insurance for individuals who lack access to group health insurance" because "[p]urchasing hospital services directly, rather than through a commercial insurer, is typically prohibitively expensive and [therefore] is not a viable substitute for group or individual health insurance."[21]

Regardless of how the Department ultimately defines the product market, the Anthem/Cigna transaction is likely to reduce competition in the sale of commercial health insurance. As shown above and discussed further below, the transaction would produce substantial increases in concentration in the sale of commercial health insurance in substantial portions of the country. Moreover, the transaction is likely to have particularly large and wide-ranging anticompetitive effects in the sale of health insurance to employers who self-insure because both parties are particularly strong in the sale of such plans.

### B. Relevant Geographic Market

To date, the Department has largely defined local relevant geographic markets in the health insurance sector. The rationale is that patients typically seek medical care close to their homes or workplaces and consequently "strongly prefer health-insurance plans with networks of hospitals and physicians that are close to their homes and workplaces."[22] As a practical matter, consumers will not select commercial health insurers that do not have a network of providers close to where they work and live.[23]

The Department's investigation of the Anthem/Cigna transaction should focus closely on the deal's impact on local markets throughout the country. However, as discussed below, this transaction also raises substantial competitive concerns for reductions in competition for national and large regional customers.

### C. Competitive Effects

Consistent with modern antitrust enforcement principles, the Department's competitive effects analysis of health insurance transactions examines both market structure and direct evidence of competition in the markets.

Market structure analysis focuses on the number of competitors, market shares, and market concentration ratios, usually the HHI. The HHI is calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. The Merger Guidelines provide that a market whose HHI is above 2,500 is "Highly Concentrated." The

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[21] Complaint at ¶¶ 22–23, *Blue Cross Blue Shield of Michigan*; *see also* Complaint at ¶¶ 25–26, *Blue Cross Blue Shield of Montana*.

[22] Complaint at ¶ 27, *Blue Cross Blue Shield of Montana*.

[23] *See id.*at ¶¶ 27–29.

Guidelines further provide that "[m]ergers 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."[24] 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.[25]

The structural evidence strongly suggests that the Anthem/Cigna transaction will reduce competition in many geographic markets. Table 1 depicts the substantial increases in concentration that the transaction would produce.

**Table 1**
**MSAs and Rural Counties in which the Post-Merger HHI Exceeds 2,500 for Commercial Lives**

| | **HHI Delta Screen** | | **Share Screen** | |
|---|---|---|---|---|
| | **>200** | **> 100** | **> 50%** | **> 35%** |
| **All Commercial Lives** | | | | |
| Number of MSAs | 600 | 817 | 355 | 498 |
| Total Commercially Insured Population | 31,231,334 | 45,034,730 | 11,325,952 | 23,692,558 |
| Anthem Membership | 10,472,094 | 12,405,109 | 5,723,016 | 9,747,303 |
| Cigna Membership | 3,706,219 | 4,755,399 | 1,254,867 | 2,613,582 |
| Membership to Divest (smaller plan) | 2,942,351 | 3,721,670 | 1,191,751 | 2,288,825 |
| Membership with no Potential Acquirer | 1,675,275 | 2,040,397 | 954,116 | 1,156,554 |

In 600 markets, the transaction will produce a post-merger HHI of more than 2,500 with a 200-point increase, generating a presumption that the transaction will result in an increase in the parties' market power. Significantly, the parties insure approximately *31.2 million* lives in these markets. In 217 markets, covering an additional *14 million* commercially insured individuals, the transaction will produce a post-merger HHI of 2,500 with a 100-200 point increase, indicating that the transaction raises significant competitive concerns for these consumers.[26]

24 *Merger Guidelines* § 5.3.

25 *See id.*

26 The calculations are based on data from January 2015 obtained from HealthLeaders-Interstudy Managed Market Surveyor, which provides information on the number of individuals who are enrolled in different health plan products by county and plan. Following Department precedent in previous investigations, we have calculated shares and HHI measures at the MSA level or, in the case of rural counties that are not part of an MSA, at the county level.

The competitive picture is equally concerning if one focuses on market shares. In 355 markets, the combined company would have a market share of at least 50 percent, and in 498 MSAs and counties, their combined share would exceed 35 percent.[27]

Because the Department often focuses on the degree of head-to-head competition between the merging parties, we also have examined the transaction's effects on competition in the sale of commercial health insurance to self-insured employers, which is the area of greatest competitive overlap. The antitrust concerns are not lower for consolidations of health insurers that sell policies to self-insured employers (often called Administrative Services Only plans, or ASO). Again, an essential service that health insurers provide is access to a provider network at competitive rates. Increasing the market power of a provider of self-insured products would allow the carrier to increase the administrative and other service fees that self-insured employers need to pay in order to obtain access to the carrier's provider network and raises other competitive concerns that negatively impact consumers.

As shown in Table 2, the competitive picture is even worse when one focuses on the sale of commercial insurance to self-insured employers.

**Table 2**
**MSAs and Rural Counties in which the Post-Merger HHI Exceeds 2,500 for Commercial ASO Lives**

| | **HHI Delta Screen** | | **Share Screen** | |
|---|---|---|---|---|
| | **>200** | **> 100** | **> 50%** | **> 35%** |
| **Commercial ASO Lives** | | | | |
| Number of MSAs | 1,009 | 1,177 | 460 | 730 |
| Total Commercially Insured Population | 38,336,781 | 43,919,746 | 14,928,252 | 24,741,274 |
| Anthem Membership | 10,915,580 | 11,314,078 | 6,818,499 | 9,275,512 |
| Cigna Membership | 6,385,014 | 6,960,004 | 2,450,874 | 4,265,669 |
| Membership to Divest (smaller plan) | 4,358,445 | 4,679,006 | 2,053,778 | 3,247,357 |
| Membership with no Potential Acquirer | 2,762,697 | 3,009,489 | 1,830,490 | 2,245,286 |

Limiting the analysis to self-insured lives, there are 1,009 MSAs and rural counties in which the merger would result in an HHI exceeding 2,500 with an HHI increase of at least 200, covering *38.3 million* self-insured commercial lives who reside in these markets. And there are 1,177 local geographic areas, with nearly *44 million* self-insured lives, for which the HHI increase exceeds 100 (and the post-merger HHI is at least 2,500). In 460 of these markets, the combined Anthem-Cigna share of self-insured commercial business would be at least 50 percent.

[27] We also apply the HHI > 2500 threshold to these calculations.

### D. Entry

The parties will no doubt argue that changes in the health care landscape would prompt entry if they were to attempt to exercise market power. Former Acting Assistant Attorney General Pozen appropriately cautioned that the Department should review such claims "carefully and with some skepticism."[28] This is in part because smaller entrants and incumbents often lack the volume to obtain prices from providers that are comparable to insurers with large market positions. The Department's challenge to Blue Cross Blue Shield of Michigan's use of most-favored nation clauses clearly set forth this market dynamic:

> Blue Cross' market power in each of the alleged markets is durable because entry into the alleged [commercial health insurance] markets is difficult. Effective entry into or expansion in commercial health insurance markets requires that a health insurer contract with broad provider networks and obtain hospital prices and discounts at least comparable to the market's leading incumbents.[29]

Indeed, one of the central insights of antitrust analysis of the health insurance markets over the last several decades is that Judge Easterbrook was likely incorrect at the time (and is certainly incorrect today) in characterizing the key input of the health insurance market as "capital" for spreading financial risk.[30] Instead, as the Department has argued in its court filings, "the core component of health insurance products today is access to a local network of health care providers at rates far lower [than] those that an individual could negotiate directly."[31]

Brand also is a substantial entry barrier in the commercial health insurance markets. Because of the importance of health insurance, and the often substantial transition costs from switching plans, employers and individuals are often very reluctant to switch to a company that lacks an established brand in the relevant geographic market. Even companies with strong positions in other regions can founder in markets in which they lack a strong track record of providing high-quality services.[32]

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28 Pozen, *Competition and Health Care* at 7.

29 Complaint at ¶ 35, *United States v. Blue Cross Blue Shield of Michigan*.

30 *Ball Mem'l Hosp. v. Mut. Hosp. Ins. Inc.*, 784 F.2d 1325, 1335 (7th Cir. 1986) (affirming district court finding "that insurers need only a license and capital, and that firms such as Aetna and Prudential have both[, and that] [t]here are no barriers to entry").

31 Plaintiff United States of America's Memorandum In Opposition to Defendant Blue Cross Blue Shield of Michigan's Motion to Dismiss the Complaint With Prejudice at 13, *United States v. Blue Cross Blue Shield of Michigan*, No. 10-cv-14155-DPH-MKM (E.D. Mich. Oct. 18, 2010). Moreover, the Tenth Circuit disagreed with *Ball Memorial* and recognized the importance of Blue Cross of Kansas's provider network, including direct contracts with local hospitals, as a source of competitive advantage over other insurers that could not until recently contract directly. *Reazin v. Blue Cross and Blue Shield of Kansas*, 899 F.2d 951, at 971–72 & n.32 (10th Cir. 1990).

32 *See* Pozen, *Competition and Health Care* at 7 ("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.")

### E. Remedies

The parties also will no doubt propose to solve any overlaps that the Department views as problematic through one-off divestiture remedies. The Department should view such remedies with skepticism. Indeed, the Department has blocked outright health insurance transactions when it doubted that a remedy could reliably fix the lost competition, as it did when Blue Cross Blue Shield of Michigan attempted to purchase Physicians Health Plan of Mid-Michigan.[33]

Our analysis demonstrates that it will be, at best, challenging for Anthem and Cigna to devise remedies that will maintain the competitive status quo. First, Table 1 provides estimates of the number of lives that would need to be divested to maintain the current market structure. Recognizing the Department's concern that the acquirer of any divested lives be equipped to compete effectively in the local area, without at the same time raising additional structural concerns, we have identified those local areas in which there is no potential acquirer who currently accounts for at least 5 percent of the covered lives and would not result in a post-acquisition HHI of 2,500 with a change in HHI of at least 100. Based on these minimal criteria, there is no viable divestiture candidate for approximately 55 percent of the lives to be divested (or 2 million consumers), who reside across 368 MSAs and rural counties.

Second, even assuming that one could solve the "nominal" structural problem through the divestitures, the Department must still ensure, as it has in the past, that the *divesting parties guarantee that the purchaser of any divested assets has a cost-competitive comparable network of hospitals and physicians*. As the Department explained in its Competitive Impact Statement for its challenge to the Blue Cross-Blue Shield of Montana/New West transaction:

> *Most importantly, Sections IV(G)–(I) [of the Final Judgment] ensure that the acquirer has a cost-competitive health-care provider network*. To compete effectively in the sale of commercial health insurance, insurers need a network of health-care providers at competitive rates because hospital and physician expenses constitute the large majority of an insurer's costs. By requiring New West and the hospital defendants to help to provide the acquirer with a cost-competitive provider network, Sections IV(G)–(I) help ensure that the acquirer will be able to compete as effectively as New West before the parties entered the Agreement.[34]

In the *Blue Cross-Blue Shield of Montana* case, because of the importance of ensuring that the acquirer had a cost-competitive network, the Department required that the hospital defendants, which owned New West, enter into three-year contracts with the buyer of the

[33] *See* Press Release, Dep't of Justice, Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans: Decision to Abandon Deal Follows Justice Department's Decision to Challenge the Acquisition (Mar. 8, 2010), http://www.justice.gov/opa/pr/blue-cross-blue-shield-michigan-and-physicians-health-plan-mid-michigan-abandon-merger-plans.

[34] Competitive Impact Statement at 17, *Blue Cross-Blue Shield of Montana*, No. 11-cv-123-RFC (D. Mont. Nov. 8, 2011) (emphasis added).

divested assets that were "substantially similar to their existing contractual terms with New West." The Department declared these contractual guarantees to be "vital" to ensuring the effectiveness of the remedy: "Because these three-year contracts provide the acquirer with a cost structure comparable to New West's costs, they position the acquirer to be competitive selling commercial health insurance in all four geographic markets."[35]

### F. Medical Loss Ratio

Finally, Anthem and Cigna may argue that the Department should lower the antitrust bar because of the margin restrictions imposed by the ACA's Medical Loss Ratio (MLR) provisions, which require that fully insured health plans spend a minimum percentage of their premiums (less taxes, licenses, and regulatory fees) on medical services and quality improvement initiatives. In particular, the ACA requires that large group insurers spend at least 85 percent of their net premium dollars on these items, while small group and individual insurers must devote at least 80 percent of them.[36]

The Department should reject this argument, as it has in the past. First, MLR requirements only apply to fully insured products. They do not cover at all the substantial competition between the parties for self-insured products. Second, the MLR requirements are not price-caps. Nothing in the requirements prevents an insurance company from increasing its costs, in order to increase prices and margins. Third, the requirements do not prevent health insurance companies from exercising market power by restricting provider networks or reducing service levels so long as they meet the minimum MLR thresholds.

## 3. Conclusion

A competitive commercial health insurance market is essential for access, affordability and innovation in the health care sector. Anthem's proposed acquisition of Cigna presents a substantial risk to such competition on an unprecedented national scope. The AHA is confident that the Department will work to protect consumers by vigorously investigating the transaction.

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35 *Id.* at 17–18.

36 *See* ACA, Pub. L. No. 111-148, § 10101(f), 124 Stat. 119, 886 (2010) (amending Public Health Service Act § 2718(b)(1)(A), 42 U.S.C. 300gg-18).