Boulder County Medical Society

June 3, 2016

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

Via US postal and email

Dear Assistant Attorney General Baer:

On behalf of the 709 members of the Boulder County Medical Society (BCMS), we are deeply grateful that your agency is investigating the proposed mergers of Aetna and Humana and Anthem and CIGNA (the "Mega Mergers")

While we will submit comments under separate cover on the Anthem-CIGNA merger, we wish to convey our opposition in the strongest possible terms to Aetna's agreement to purchase Humana, and to protest Colorado Division of Insurance's approval of this merger without notice to the public or input from physicians and other stakeholders.

Only an insurance attorney could sell with a straight face the logic of Colorado law followed by the Colorado Division of Insurance, the one agency charged with state oversight, to approve the Aetna-Humana merger.

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

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

Aetna acknowledges that its acquisition of Humana is "primarily about Medicare."[1] As discussed below, the merger would substantially increase the market concentration in Medicare Advantage (MA) within Boulder County. Aetna's response is that MA consumers have the option of switching between MA and traditional Medicare (TM) operated by the government.[2] Moreover, claims Aetna, MA is not a relevant product market because any small but significant and non-transitory increase in the quality adjusted price of MA demanded by a combined Aetna/Humana would be defeated by the government as a competitor offering TM.

[1] *See*, Testimony of Mark Bertolini, CEO of Aetna, United States Senate Committee on the Judiciary (September 22, 2015) at 2.
[2] *See*, Id at 5.

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Aetna has mischaracterized the federal government's role. The federal government is not an Aetna competitor attempting to compete for Medicare business. Instead the government is a purchaser procuring competitive bids from private health insurers competing to offer MA plans to Medicare beneficiaries.[3] Congress's goal in establishing the MA program was "that vigorous competition among private MA insurers…would lead those insurers to offer seniors a wider array of health insurance choices and richer and more affordable benefits than TM does, and be more responsive to seniors."[4] In the event Aetna were to acquire Humana, and competition for the government contract and MA beneficiaries were lessened, the government would actually be harmed, not advantaged, as would be the case if it were a competitor, by the higher prices and/or poorer service offered by a combined Aetna/Humana in MA.[5] Accordingly, once the government is understood as a purchaser, there is a relevant MA market in which the proposed acquisition clearly lessens competition substantially.

Moreover, seniors are not likely to switch away from MA plans to TM in sufficient numbers to make an anticompetitive Aetna price increase or reduction in quality unprofitable. In MA plans, Medicare pays most or all of the premiums to a private insurer.[6] Most MA plans are health maintenance organizations (HMOs).[7] In return for reduced choice of providers and utilization review, the Medicare beneficiary obtains more complete coverage. A Medicare beneficiary who wants to join an HMO has no other practical choice. TM is a very different type of plan than MA plans.[8] It has no panels and no serious utilization review.[9] Indeed, TM is the only surviving large-scale example of traditional indemnity insurance[10]

TM provides unrestricted choice of provider but its benefit design exposes a beneficiary to risk of high out-of-pocket responsibilities. In 2013-14, 16 percent of Medicare beneficiaries faced out-of-pocket responsibilities that exceeded 20 percent of their annual income.[11] Purchase of a private Medicare supplement can reduce the risk of high out-of-pocket responsibilities, but at a fairly high cost.[12] MA insurance, on the other hand, leads to less risk of high out-of-pocket responsibilities. MA plans cover more services than TM and they are required to have an out-of-pocket maximum that limits the risk exposure of beneficiaries. In MA plans, the average out-of-pocket maximum was $5,014 per year per beneficiary in 2015.[13]

Consent decrees that the U.S. Department of Justice (DOJ) has entered into with Humana and Arcadian Management and with UnitedHealth Group and Sierra Health Services (Consent

[3] For an explanation of the competitive bidding process, See Song, Landrum and Chernew, "Competitive Bidding and Medicare Advantage: Effect of Benchmark Changes Unplanned Bids", Journal of Health Economics 32 (2013) 1301-1312. http://www.ncbi.nlm.nih.gov/pubmed/24308881 .

[4] *See*, United States v. Humana and Arcadian Management, No. 12-cv-00464 (D.D.C. Mar. 27, 2012) (complaint) (*avail. at* http://www.justice.gov/atr/case-document/file/499076/download)

[5] A Center for American Progress Study has concluded that Medicare program spending would increase as a result of the merger. Spiro, Calsyn, O'Toole, "Bigger is not Better: Proposed Insurer Mergers are Likely to Harm Consumers and Taxpayers," Center for American Progress (Jan. 21, 2016)

[6] *See,* Comments of H.E. Frech III PhD, Professor of Economics, University of California, Santa Barbara (May 19, 2016) (Comments of Professor Frech) at 12. (Exhibit A)

[7] Id.

[8] Id.

[9] Id.

[10] Id.

[11] Id.

[12] Id.

[13] Id at 12-13.

Decrees) rightly observe that TM is not an adequate substitute for MA because MA plans offer substantially richer benefits at lower costs than TM, including lower copayments, lower coinsurance, caps on total yearly out-of-pocket costs, prescription drug coverage, and supplemental benefits that TM does not cover, such as dental and vision coverage, and health club memberships.[14] Moreover, in MA plans, seniors can receive a single plan covering a variety of benefits that seniors in TM must assemble themselves.

The combination of richer benefits and one stop shopping accounts for the strong preference by many seniors for MA plans. Over the long-term, MA plans are slowly increasing in share, attracting 31 percent of Medicare beneficiaries in 2015.[15] Research is consistent with the idea that beneficiaries treat MA plans as distinctly preferable to TM. Analysis of MA enrollees who were terminated because their plan left the market overwhelmingly (95 percent) actively sought another MA plan.[16]

Further, MA utilization control for hospitals appears to be quite strict, lending force to the idea that MA and TM are functionally different products.[17] A recent study has found that when MA beneficiaries had to switch to TM, their hospital utilization and costs rose substantially.[18]

Consequently, the closest competition to one MA insurer's plan is another insurer's MA plan and the presence of many competing MA insurers is what keeps quality and price competitive. This conclusion is buttressed by a recent study finding that when Humana offers a MA plan in the same county as Aetna, Aetna's premium is lower than in counties where Humana does not offer a plan.[19]

Additional research indicates that where there are fewer MA insurers, premiums are higher, showing that neither TM nor commercial insurance is a serious constraint on MA pricing, regardless of the number or concentration of other insurers, in that market.[20]

In sum, Aetna and Humana compete for consumers in an MA product market that is separate and distinct from TM. This was the conclusion announced on May 25 by the Missouri Department of Insurance on Aetna's application to acquire Humana.[21] After considering an exhaustive record that included the comments of consumer and provider groups and the testimony of the merging parties and expert health economists, the department found that Medicare Advantage satisfies all of the practical indicia of a relevant antitrust product market. The department further concluded that an Aetna / Humana merger in the MA markets would violate the competitive standard established under state insurance law. Accordingly, the Missouri Insurance Department ordered

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[14] United States v. Humana and Arcadian Management, No. 12-cv-00464 (D.D.C. Mar. 27, 2012) (complaint ¶¶ 20-21) (*avail. at* http://www.justice.gov/atr/case-document/file/499076/download); United States v. UnitedHealth Grp. Inc. & Sierra Health Servs., Inc., No. 08-cv-00322 (D.D.C. Feb. 25, 2008) (complaint ¶¶ 15-18) (*avail. at* http://www.justice.gov/atr/case-document/file/514126/download). Paragraph 2.

[15] *See,* Comments of Prof. Frech at 12

[16] Id. at 13.

[17] Id. at 13.

[18] Id at 13.

[19] Spiro et al, supra n. 7

[20] *See,* Comments of Prof. Frech at 13-14.

[21] *See* Findings of Fact, Conclusions of Law and Order, Missouri Department of Insurance, In Re Division of Insurance Company Regulation v. Aetna Inc. and Humana Inc.(May 24, 2016) (Exhibit B)

that if Aetna merged with Humana, the merged firm could do business in neither the group MA market in Missouri nor the individual MA markets in sixty-five Missouri counties, including counties containing large metropolitan areas, such as St. Louis and Kansas City. As will be explained below, the proposed Aetna/Humana merger in Colorado will be similarly anticompetitive in MA markets.

The Mergers Would Be Anticompetitive in Already Highly Concentrated Colorado Medicare Advantage Markets, Including Boulder County

Data from the Centers of Medicare & Medicare Services reveal the structural anticompetitive consequences of an Aetna - Humana merger in MA markets. In 2015 the four firm concentration ratio (CR4) –the Colorado statutory measure of market concentration obtained by adding up the percentage market shares of the four largest firms – was 95.6% in a MA market consisting of the state of Colorado. This far surpasses the 75% CR 4 threshold that Colorado law utilizes in characterizing a market as "highly concentrated".[22]

Also in 2015, Humana's statewide MA market share was 14.4%, up 50% since 2010. Aetna's was 1.5%. Under Colorado statute, when in a highly concentrated market a firm with a 15% share (and Humana's 14.4 % share would seem close enough, especially given its rapid growth rate) merges with a firm like Aetna with a 1% or more share, or a firm with a 10% share merges with a firm with a 2% share, there is a *prima facie* violation of the competitive standard.[23] The shares of Aetna and Humana are close enough to a prima facie violation to at least create a factual question of whether the effect of the merger may be to "substantially lessen competition", the ultimate criterion found in the Colorado insurance statute.

Turning to MSA markets for Medicare Advantage, the CR4 for Boulder is 95.8%, far surpassing the 75% threshold describing a highly concentrated market. Humana's share of Boulder's MA market is 10.2% and Aetna's is 3.7% . These shares are more than enough to create a *prima facie* violation of Colorado's competitive standard.

Barriers to Entry

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

[22] *See* C.R.S. § 10-3-803.5 (4).
[23] Id.
[24] *See* Robert W. McCann, *Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field,"* Health Law Handbook (Thomson West 2007); Mark V. Pauly, *Competition in Health Insurance Markets*, 51 Law & Contemp. Probs. 237 (1988); Federal Trade Commission and U.S. Department of Justice, Improving Health Care: A Dose of Competition

expansion in the health insurance industry found that "brokers typically are reluctant to sell new health insurance plans, even if those plans have substantially reduced premiums, unless the plan has strong brand recognition or a good reputation in the geographic area where the broker operates."[25]

Perhaps the greatest obstacle is the so-called chicken and egg problem of health insurer market entry: health insurer entrants need to attract customers with competitive premiums that can only be achieved by obtaining discounts from providers. However providers usually offer the best discounts to incumbent insurers with significant business—volume discounting that reflects a reduction in transaction costs and greater budget certainty. Hence, incumbent insurers have a durable cost advantage.[26]

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

> [B]ased on our interviews of market participants and other evidence, there are a number of barriers to entry—including the provider cost advantage enjoyed by the dominant firms in those areas and the strength of the Blue brand in those areas...On balance, the evidence suggests that to the extent the proposed consolidation reduces competition, it is unlikely that other health insurance firms will be able to step in and replace the loss in competition.[27]

The merging health insurers have argued that times have changed and the health insurance marketplaces have made entry easy. The facts however do not bear out that claim. Recent state developments only highlight the barrier to entry problem. The *New York Times* recently reported "tough going for health co-ops" created under the Affordable Care Act (ACA) to inject competition into health insurance markets.[28] According to the *New York Times*, many co-ops "appear to be scrambling to have enough money to cover claims as well as enroll new customers as they enter their third year." According to the *Washington Post* of October 10, 2015, nearly half of the 23 ACA insurance co-ops, subsidized by millions of dollars in government loans, have been told by federal regulators that their finances, enrollment, or business model need to

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(July,2004); *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 Law & Contemp. Probs. 195 (1988).

[25] 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.

[26] Id. at 7.

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

[28] "Tough going for Co-ops," the New York Times, September 15, 2015, available at http://www.nytimes.com/2015/09/16/business/health-cooperatives-find-the-going-tough.html?ref=health

"shape up." One co-op has folded and four others were preparing to close in late December, including top-tier co-ops that federal officials had regarded as best poised to succeed.[29] More closure announcements are expected.[30] The quick death of these co-ops illustrate that even with heavy federal subsidies, health insurance is a tough business to enter.

THE PROPOSED MERGER IS LIKELY TO HARM CONSUMERS

The AMA has evaluated the potential effects of the proposed megamerger on both (1) the sale of MA products to individuals (the sell side); and (2) the purchase of health care provider (including physician) services (the buy side).[31] The AMA has concluded that on the sell side the merger is likely to result in higher premium levels to MA recipients and/or a reduction in the quality of health insurance that can take the form of a reduction in the availability of providers, a reduction in consumer service, etc. On the buy side, the merger could enable the merged entity to lower payment rates for physicians such that there would be a reduction in the quality or quantity of the services that physicians are able to offer patients.

Likely Detrimental Effects for Consumers in the MA Market

Price Increases

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

Two studies have examined the effects of past health insurance mergers on premiums. A study of the 1999 merger between Aetna and Prudential found that the increased market concentration was associated with higher premiums.[32] Most recently, a second study examined the premium impact of the 2008 merger between UnitedHealth Group Inc. and Sierra Health Services. That merger led to a large increase in concentration in Nevada health insurance markets. The study concluded that in the wake of the merger, premiums in Nevada markets increased by almost 14 percent relative to a control group. These findings suggest that the merging parties exploited their resulting market power, to the detriment of consumers.[33]

Also, recent studies suggest premiums for employer sponsored fully insured plans are rising more quickly in areas where insurance market concentration is increasing.[34]

Consistent with the observation that the loss of competition accompanying health insurer mergers results in higher premiums is research finding that competition among insurers is

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

[30] Id.

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

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

[33] Jose R. Guardado, David W. Emmons, and Carol K. Kane, "The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra" *Health Management, Policy and Innovation*, 2013; 1(3) 16-35.

[34] Dafny, supra note 1, at 11.

associated with lower premiums.[35] Research suggests that on the federal health insurance marketplaces, the participation of one new large carrier (i.e. UnitedHealth Group Inc.) would have reduced premiums by 5.4 percent, while the inclusion of all companies in the individual insurance markets could have lowered rates by 11.1 percent.[36] Professor Dafny observes that there are a number of studies documenting lower insurance premiums in areas with more insurers, including on the state health insurance marketplaces, the large group market, and in MA.[37] For example, a recent study found that when Humana offers a MA plan in the same county as Aetna, Aetna's premium is lower than in counties where Humana does not offer a plan.[38] Moreover, as we noted above, additional research indicates that where there are fewer MA insurers, premiums are higher[39]

Plan Quality

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

While the relationship between insurer consolidation and plan quality requires additional research, one study in the MA market found that more robust competition was associated with greater availability of prescription drug benefits.[40] As Professor Dafny observes, "the competitive mechanisms linking diminished competition to higher prices operate similarly with respect to lower quality."[41]

<u>The Monopsony Power Acquired through the Merger Would Likely Degrade the Quality and Reduce the Quantity of Physician Services.</u>

Just as the merger would enhance market power on the selling side of the MA market, it would also enhance monopsony or buyer power in the purchase of inputs such as physician services, eviscerating physicians' ability to contract with alternative MA plans in the face of unfavorable contract terms and ultimately inefficiently reducing the quality or quantity of services that physicians are able to offer patients. As Professor Dafny explained in her recent Senate testimony on this merger, "[M]onopsony is the mirror image of monopoly; lower input prices are achieved by reducing the quantity or quality of services below the level that is socially

[35] Dafny et al., supra note 1, at 11.
[36] Leemore Dafny, Jonathan Gruber and Christopher Ody. "More Insurers, Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces," *American Journal of Health Economics,* 2015: 1(1)53-81.
[37] Dafny supra note 1, at 11.
[38] Spiro et al, supra n. 7
[39] *See,* Comments of Prof. Frech at 13-14.
[40] Dafny supra, note 1 at 11.
[41] Robert Town and Su Liu, "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* (2003): 719-736.

optimal."[42] She further explained that the "textbook monopsony scenario…pertains when there is a large buyer and fragmented suppliers."[43] This characterizes the market in which dominant health insurers purchase the services of physicians who typically work in small practices with 10 or fewer physicians.[44]

Even if in the Boulder county market for MA the merged health insurer were found to lack market power to raise the quality- adjusted premiums for patients, the insurer still likely has the power to force down physician compensation to anticompetitive levels.[45] This is because physicians could not readily replace lost business by refusing the insurer's contract and dealing with other payers without suffering irretrievable lost income.[46] It is difficult to convince consumers (which in MA are elderly patients) to switch to different health insurers.[47] Also, switching health insurers is a very difficult decision for physicians because it impacts their patients and disrupts their practice. The patient-physician relationship is a very important aspect to the delivery of high-quality healthcare. And it is a very serious decision both personally and professionally for physicians to disrupt this relationship by dropping a health insurer. Thus, in the UnitedHealth Group Inc./PacifiCare merger, the DOJ required a divestiture based on monopsony concerns in Boulder, Colorado, even though the merged entity would not necessarily have had market power in the sale of health insurance. The reason is straightforward: the reduction in compensation would lead to diminished service and quality of care, which harms consumers even though the direct prices paid by subscribers do not increase.[48]

In another merger matter occurring in 2010—Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan—the health insurers abandoned their merger plans when the DOJ complained that the merger "…would have given Blue Cross Michigan the ability to control physician payment rates in a manner that could harm the quality of healthcare delivered to consumers."[49]

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[42] Dafny, supra note 1, at 10.

[43] Id.

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

[45] Comments of Prof. Frech at 7 ("…the threat of losing even a small percentage of commercially-insured volume may allow an insurer to reduce prices or gain other contractual benefits. Therefore, buyer-side market power is likely to be a problem at lower concentration levels than on the seller side.")

[46] See Capps, Cory S., Buyer Power in Health Plan Mergers (June 2010). Journal of Competition Law and Economics, Vol. 6, Issue 2, pp. 375-391.

[47] See e.g. *U.S. v. UnitedHealth Group and Pacificare Health Systems*., Complaint, No. 1:05CV02436, ¶ 37 (December 20, 2005), available at http://www.justice.gov/file/514011/download. (As alleged in the United/PacifiCare complaint, physicians encouraging patients to change plans "is particularly difficult for patients employed by companies that sponsor only one plan because the patient would need to persuade the employer to sponsor an additional plan with the desired physician in the plan's network" or the patient would have to use the physician on an out-of-network basis at a higher cost).

[48] *See* Gregory J. Werden, *Monopsony and the Sherman Act: Consumer Welfare in a New Light*, 74 ANTITRUST L.J. 707 (2007) (explaining reasons to challenge monopsony power even where there is no immediate impact on consumers); Marius Schwartz, *Buyer Power Concerns and the Aetna-Prudential Merger,* Address before the 5th Annual Health Care Antitrust Forum at Northwestern University School of Law 4-6 (October 20, 1999) (noting that anticompetitive effects can occur even if the conduct does not adversely affect the ultimate consumers who purchase the end-product), available at: http://www.usdoj.gov/atr/public/spceches/3924.wpd.

[49] Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans | OPA | Department of Justice, available at: http://www.justice.gov/opa/pr/blue-cross-blue-shield-michigan-and-physicians-health-plan-mid-michigan-abandon-merger-plans.

The DOJ's monopsony challenges properly reflect its conclusions that it is a mistake to assume that a health insurer's negotiating leverage acquired through merger is a good thing for consumers. On the contrary, consumers can expect higher insurance premiums."[50] Health insurer monopsonists typically are also monopolists.[51] Facing little if any competition, they lack the incentive to pass along cost savings to consumers.

Consumers do best when there is a competitive market for purchasing physician services. This was the well-documented conclusion reached in the 2008 hearings before the Pennsylvania Insurance Department on the competition ramifications of the proposed merger between Highmark, Inc. and Independence Blue Cross. Based on an extensive record of nearly 50,000 pages of expert and other commentary,[52] the Pennsylvania Insurance Department was prepared to find the proposed merger to be anticompetitive in large part because it would have granted the merged health insurer undue leverage over physicians and other health care providers. This leverage would be "to the detriment of the insurance buying public" and would result in "weaker provider networks for consumers who depend on these networks for access to quality healthcare."[53] The Pennsylvania Insurance Department further concluded

> [O]ur nationally renowned economic expert, LECG, rejected the idea that using market leverage to reduce provider reimbursements below competitive levels will translate into lower premiums, calling this an "economic fallacy" and noting that the clear weight of economic opinion is that consumers do best when there is a competitive market for purchasing provider services. LECG also found this theory to be borne out by the experience in central Pennsylvania, where competition between Highmark and Capital Blue Cross has been good for providers and good for consumers.[54]

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

Such reduction in service levels and quality of care causes immediate harm to consumers. In the long run, it is imperative to consider whether monopsony power will harm consumers by driving physicians from the market. Health insurer payments that are below competitive levels may reduce patient care and access by motivating physicians to retire early or seek opportunities

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[50] Dafny, supra note 1, at 9.
[51] Peter J. Hammer and William M. Sage, *Monopsony as an Agency and Regulatory Problem in Health Care*, 71 ANTITRUST. L.J. 949 (2004).
[52] See *http://www.ins.state.pa.us/ins/lib/ins/whats_new/Excerpts_from_PA_Insurance_Dept_Expert_Reports.pdf* for background information, including excerpts from the experts.
[53] *See* Statement of Pennsylvania Insurance Commissioner Joel Ario on Highmark and IBC Consolidation (January 22, 2009).
[54] Id.

outside of medicine that are more rewarding, financially or otherwise. According to a 2015 study released by the Association of American Medical Colleges, the U.S. will face a shortage of between 46,000-90,000 physicians by 2025. The study, which is the first comprehensive national analysis that takes into account both demographics and recent changes to care delivery and payment methods, projects shortages in both primary and specialty care.[55] Recent projections by the Health Resources and Services Administration similarly suggest a significant shortage of primary care physicians in the United States.[56]

According to a recent survey by Deloitte, six in 10 physicians said it was likely that many physicians would retire earlier than planned in the next one to three years, a perception that Deloitte stated is fairly uniform among all physicians, irrespective of age, gender, or medical specialty.[57] According to the Deloitte survey, 57 percent of physicians also said that the practice of medicine was in jeopardy and nearly 75 percent of physicians thought that the "best and the brightest" may not consider a career in medicine. Finally, most physicians surveyed believed that physicians would retire or scale back practice hours, based on how the future of medicine is changing.[58]

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

BOULDER CMS MEMBERS STRONGLY OPPOSE THE AETNA HUMANA MERGER:

Colorado Medical Society conducted an on-line member survey on the mergers between December 29, 2015 and January 2016. We have been advised that CMS provided your agency with the statewide survey results and herewith is the data for BCMS members.[59] It is worth noting that, after the pros and cons of the mergers were presented, not a single respondent either 'strongly' or 'somewhat' favored allowing the mergers to proceed.

MERGER EFFICIENCY CLAIMS ARE UNSUPPORTED AND SPECULATIVE

Professor Dafny noted in her Senate testimony that claims of offsetting efficiencies cannot ameliorate the competitive harm from these mergers. "Efficiencies must be merger-specific and verifiable…and there is still the question of whether benefits will be passed through to consumers in light of that diminished competition."[60] Insurers have a dismal track record of passing any savings from an acquisition on to consumers, and there is no reason to believe that

[55] *See* IHS Inc., The Complexities of Physician Supply and Demand: Projections from 2013 to 2025. Prepared for the Association of American Medical Colleges. Washington, DC: Association of American Medical Colleges; 2015.
[56] *See* Health Resources and Services Administration, Projecting the Supply and Demand for Primary Care Physicians through 2020 in Brief (November 2013).
[57] Deloitte 2013 Survey of U.S. Physicians: Physician perspectives about health care reform in the future of the medical profession.
[58] Id.
[59] *See*, Health Plan Mergers 2015-2016-BCMS (Exhibit C).
[60] Dafny, supra note 1, at 16.

this transaction would be any different. Under these circumstances, we suggest that regulators review the merging insurers' efficiency claims with skepticism similar to that expressed by the Ninth Circuit Court of Appeals in the merger case of *St. Alphonsus Medical Center and Federal Trade Commission v. St. Luke's*, 778 F.3d 775 (9th Cir, 2015). ("The Supreme Court has never expressly approved an efficiencies defense to a section 7 claim…We remain skeptical about the efficiencies defense in general and about its scope in particular.")[61]

Turning to the health insurers' specific efficiency claims,

> [T]here is no evidence that larger insurers are more likely to implement innovative payment and care management programs…[and] there is a countervailing force offsetting this heightened incentive to invest in…reform: more dominant insurers in a given insurance market are less concerned with ceding market share.[62]

In fact, "concerted delivery system reform efforts have tended to emerge from other sources, such as provider systems…and non-national payers," according to Professor Dafny, not from commercial health insurers.[63]

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

THE DEPARTMENT OF JUSTICE SHOULD DISREGARD AND REJECT COLORADO DIVISION OF INSURANCE APPROVAL OF THE AETNA HUMANA MERGER.

On July 3, 2015, Aetna announced an agreement to purchase Humana for $37 billion. On July 24, 2015, Anthem, a Blue Cross Blue Shield insurer, agreed to acquire all outstanding shares of CIGNA for an estimated $54.2 billion.

On August 7, 2015, the Colorado Medical Society (CMS) expressed to Colorado State Insurance Commissioner Marguerite Salazar its concern, shared by BCMS, that the proposed mega mergers if approved, would likely have anticompetitive consequences for physicians and their patients across Colorado. CMS also urged Commissioner Salazar to conduct a hearing on the proposed mega mergers to determine whether they would constitute a violation of Colorado's competitive standard and that she conduct an independent analysis as provided for in C.R.S. § 10-3-803 again with the support of BCMS. CMS further requested that the Division of Insurance provide notice to CMS of any proposed orders and hearings relating to these mergers. Subsequently, CMS met with Commissioner Salazar and provided her with data demonstrating the perilous levels of market concentration at both the statewide and MSA levels in Colorado, including Boulder County, should the mergers be approved.

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[61] *St. Alphonsus Medical Center and Federal Trade Commission v. St. Luke's*, 778 F.3d 775, 789-790 (9th Cir, 2015)
[62] Dafny, supra note 1, at 16.
[63] Id.

The proposed health insurer mergers have put a spotlight on the laws that require the Colorado Division of Insurance (DOI) to review such mergers. The merger between Anthem and Cigna is governed by a law applying to domestic insurers. However, Aetna and Humana are both foreign insurers under Colorado law. Although Aetna provided DOI with notice of the proposed acquisition of Humana last summer, current law does not require nor prohibit DOI to provide notice to the public or stakeholders that it was reviewing the proposed deal. DOI disregarded requests for notice from CMS and others. After 30 days passed without action by DOI, the merger was considered approved under Colorado law, without notice to or input from physicians or consumers.

CMS took action to determine why DOI approved the Aetna-Humana merger without public notice or input. Using Colorado's Open Records Act, CMS demanded from DOI a copy of the pre-acquisition notice Form E, filed with DOI by Aetna. Aetna's Form E contains Colorado market share information Aetna submitted regarding the proposed merger. In response to CMS' CORA request, DOI filed a lawsuit in Denver district court asking a judge to determine whether Aetna's Form E is confidential under Colorado law. Aetna was joined in that lawsuit and the court.

A Denver district court judge ruled in late April that the Form E filed by Aetna in the proposed Aetna-Humana merger is not a public document under Colorado law because Aetna is a foreign insurer, but that the Commissioner of the Division of Insurance has the discretion to release the Form E if it is in the public interest. The judge further ruled that any Form E filed by a domestic insurer, which includes both Anthem and Cigna, is a public document. Aetna at a hearing held in court on April 21, before the judge's ruling, argued to the court in part that the Form E should be confidential because it contains "admissions" regarding the competitive impact the proposed merger will have in Colorado. This was the precise reason CMS generated the CORA request. The Aetna attorney's statement is also consistent with records obtained from a second CMS CORA request to DOI for all documents about the merger which show DOI concluded the merger violates the competitive standard contained in Colorado law for two lines of health insurance. Despite Aetna's admissions in the Form E, DOI went on to approve the merger through inaction, ostensibly finding that one or both exceptions apply to permit the merger. The two permissible exceptions under Colorado law are that the proposed merger will not create a statewide monopoly or that it will not substantially lessen competition among health insurers in the lines violating the competitive standard. The problem with these exceptions is that they apply only statewide and do not account for the proposed merger's impact on the local healthcare markets where providers practice and patients seek medical care.

Because the judge held that the Aetna Form E is not a public document, the part of the statute which addresses confidential information applies to it. That section vests discretion in the DOI Commissioner to release otherwise confidential information and documents after giving the carrier notice and an opportunity to be heard when the Commissioner determines that the interest of policyholders, shareholders or the public will be served by publication. CMS has requested that the Commissioner release the Aetna Form E under this section as clearly being in the public interest.

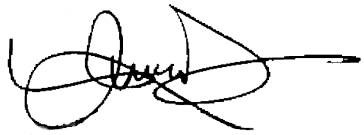
The judge also distinguished between Form E filings by domestic and foreign insurance carriers since the statute that applies to insurance company mergers contains separate, although overlapping and interacting, parts. The judge concluded that the legislature intended for there to be increased public scrutiny of mergers involving domestic insurance carriers compared to those involving only foreign insurance carriers. This reasoning, even if a valid interpretation of the law, underscores another overarching problem with the law. Even as foreign insurers under Colorado law, Aetna and Humana are both among the top six health insurers in the state and do substantial business in certain health insurance lines and local markets. The competitive impact of this proposed merger involving two "foreign" insurance companies will be as significant and real on providers and patients in those markets as a merger involving "domestic" insurers.

The CMS document production request has also revealed a serious flaw in the DOI analysis. The department used solely the state of Colorado as the relevant geographic market when it was not required to do so. In determining the relevant geographic market, the Commissioner is to assume that the relevant geographic market is the state only "in the absence of sufficient information to the contrary"[64] The evidence is that markets for the sale of health insurance and the markets in which health insurers exercise market power in the purchase of physician services are local; in most cases no bigger than counties and sometimes smaller than counties.[65] The DOI therefore improperly ignored the likely substantial anticompetitive impact that an Aetna acquisition of Humana would likely have in the health insurance and physician markets in Boulder County.

For these reasons the BCMS respectfully urges the Department of Justice to block the Aetna-Humana merger.

If you have questions, or need additional information, please do not hesitate to contact me.

Sincerely,



Leto Quarles, MD, President
Boulder County Medical Society

Copies to:

The Honorable John Hickenlooper, Governor of Colorado
The Honorable Joe Neguse, Executive Director, Colorado Department of Regulatory Affairs
The Honorable Marguerite Salazar, Commissioner, Colorado Division of Insurance
The Honorable Michael Bennet, US Senator for Colorado

[64] C. R. S. §10-3-803.5 (d) (II)
[65] See, Comments of Prof. Frech at 15-23.

The Honorable Cory Gardner, US Senator for Colorado
The Honorable Jared Polis, US Congressman for Colorado US House District 2
Boulder County State Legislative Delegation:
- Senator Rollie Heath
- Senator Matt Jones
- Senator Tim Neville
- Representative KC Becker
- Representative Mike Foote
- Speaker of the House Dickey Lee Hullinghorst
- Representative Dianne Primavera
- Representative Jonathan Singer

James Madera, MD, Executive Vice-President and CEO, American Medical Association
Mike Volz, MD, President, Colorado Medical Society
Katie Lozano, MD, President-elect, Colorado Medical Society
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Alfred Gilchrist, Chief Executive Officer, Colorado Medical Society
Susan Koontz, JD, CMS General Counsel and Senior Director of Government Relations