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Testimony

of the

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Subcommittee on Regulatory Reform, Commercial and Antitrust Law

of the

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of the

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"Healthy Competition? An Examination of the Proposed Health Insurance Mergers and the Consequent Impact on Competition"

September 29, 2015

I am Tom Nickels, executive vice president of the American Hospital Association (AHA). On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, I thank you for the opportunity to testify.

The AHA has expressed concern in numerous forums about the proposed acquisition of Cigna by Anthem and Humana by Aetna. These acquisitions would further concentrate an already heavily concentrated health insurance industry. In addition, any potential benefits the deals could yield pale in comparison to the enduring harm the deals could impose on health care consumers and providers. Many consumer and provider organizations have raised similar concerns, urging that these deals receive the closest possible scrutiny by federal and state antitrust authorities.

Among the claims that the insurers make to defend the acquisitions of their closest competitors are that the companies are complementary without significant overlaps and/or allow them to extend to lines of business they could not enter otherwise. These claims have – and should have – been met with significant skepticism. That also is true of their statements declaring that all health care is "local," followed by a recitation of national statistics on the number of supposed

competitors to imply that there is more than sufficient competition in local markets. However, this is not the case. If all health care is local, then only the competitors in a particular local market count in assessing the anticompetitive impact of the deal. Our analyses, which are done in the same manner and with the same data that the Department of Justice (Department) would use in making competitive assessments, show that more than 800 markets for the Anthem deal and more than 1,000 markets for the Aetna deal lack sufficient "local" competitive alternatives.

The same attempt at obscuring applies to claims by Anthem that its Blue Cross Blue Shield (Blue) affiliation would not limit its ability to deploy the Cigna business as an effective competitive force or further entrench the dominance of Blues plans across the nation. "The Blues' license agreements severely restrict the Blues' ability to compete with each other," and that has tremendous anticompetitive potential, perhaps even beyond those we have identified.[1]

Both of these proposed deals could be an enduring blow to consumers as well as hospitals, doctors and others who work to improve the quality, efficiency and affordability of health care. As Professor Leemore Dafny highlighted in her recent testimony before the Senate, health insurance "consolidation that occurs now is unlikely to be undone if it later proves anticompetitive," as most expect it will.[2]

Hospitals' momentum to move the nation's health care system forward could also sustain long-term irreversible damage as a result of these deals. Despite the commercial insurers' recent claims that they are fostering innovation, they continue to benefit financially from letting hospitals do most of the hard work of reducing readmissions, improving (rigorously measured) patient quality, experimenting with accountable care organizations (ACOs) and bundling programs, instituting population health programs and numerous other efforts designed to turn a system predicated on volume to one measured by value. As Dafny noted, "[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."[3] In fact, "concerted delivery system reform efforts have tended to emerge from other sources, such as provider systems … and non-national payers," according to Dafny, not commercial health insurers.[4]

Neither of the proposed acquisitions should be permitted to move forward until federal and state antitrust and insurance authorities can offer assurances that they are procompetitive, will not leave consumers with fewer and more expensive options for coverage or diminish insurers' willingness to be innovative partners with providers to move our health care system beyond silos to a continuum of care that is responsive to consumers' needs.

SERIOUS CONCERNS ABOUT HEALTH INSURANCE CONSOLIDATION

The AHA recently shared with the Department's Antitrust Division our serious concerns about the recently announced acquisitions.[5] These deals would eliminate two of the largest national health insurance companies, leaving just three dominant providers of health insurance, and an even more consolidated health insurance market. Recent American Medical Association (AMA)

data on health insurance concentration confirms that consolidation is widespread – 70 percent of health insurance markets are "highly concentrated."[6]

Concentration Matters. A recent study[7] in *Technology Science* highlighted why this increasing concentration should be of particular concern. It found that the largest issuer in each state not only raised premiums by higher amounts, but also raised premiums on more of their plans than other issuers in the same state.

Anthem's Acquisition of Cigna Threatens to Reduce Competition on a Massive Scale.

> "The potential harm to consumers from the loss of competition that could result from the Anthem/Cigna transaction is large and durable. Because the two companies generate more than $100 billion in revenue, even a modest price increase would cost consumers billions of dollars in higher health care costs."[8]

The geographic reach of the transaction would be sweeping. It threatens to reduce competition for commercial health insurance in at least 817 markets across the U.S. that serve 45 million consumers. In each of these markets, the transaction would produce a Herfindahl-Hirschman Index (HHI) score of 2,500 or more, which the merger guidelines indicate either raise serious or virtually insurmountable competitive issues.

The parties' attempt to explain the substantial competition between them by creating artificial "submarkets" should be viewed with great skepticism. Typically, when companies go to such lengths, it is to obscure competitive overlaps in a desperate effort to demonstrate that a market is competitive. In fact, both companies acknowledge in their public statements that they compete vigorously for the same group of customers, including large group customers. Moreover, even if such market stratification were valid and the companies do not actually compete in the regions in which they both actively sell commercial insurance, it would reflect enormously high entry barriers and raise questions about anticompetitive coordination (which also should be investigated) and, of course, underscore the deal's enormous anticompetitive potential.

Entry is Daunting. The durability of the likely anticompetitive impact is enhanced because of the high barriers to entry in the commercial health insurance market. The Department has explicitly acknowledged this and, remarkably, little has changed over the three years since that authoritative pronouncement.[9] The insurers point to some recent new entries to suggest that the barriers are lower now; however, this could not be further from the facts.

Specifically, the insurers point to Oscar, one of only two for-profit "companies that were not already insurers … to enter state marketplaces so far."[10] To date, Oscar has penetrated only a single urban market (New York/New Jersey) and is attempting to enter two more in 2016.[11] In doing so, it lost a reported $27.5 million last year, or about half of its 2014 revenue.[12] In addition, it does not discount the immense difficulty of building this business in a market "dominated by powerfully entrenched business;" the company's founder described entry into the insurance market as "daunting."[13]

This month, the *New York Times* chronicled the failure of numerous health insurers across the nation, citing a report that "eight carriers have dropped out of nine states" so far.[14] The fact remains that "the most likely potential entrants in a [health insurance] market are incumbents in other product and/or geographic markets," such as the companies seeking to consolidate now.[15]

As Dafny noted in her Senate testimony, claims of offsetting efficiencies cannot ameliorate the competitive harm from this deal. "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."[16] Insurers have a dismal track record of passing any savings from an acquisition on to consumers, and there is no reason to believe that this transaction would be any different.[17]

Legislated Controls Cannot Prevent Premium Hikes. Neither of the legislated controls on excessive premium hikes – medical loss ratio (MLR) or rate review – are sufficient to prevent Anthem from raising rates to consumers above competitive levels. Among other things, the MLR is "gameable" by insurers.[18] Our MLR factsheet is attached.

The MLR measures how much of the premium dollar goes to pay for medical claims and quality activities instead of administrative costs and marketing. Despite its seeming promise, the MLR will not be effective in controlling premium cost increases because: the MLR requirements apply to fewer than 50 percent of Americans under age 65 with health insurance coverage; the rules for reporting MLRs may mask differences in premiums rate increases; and the MLR does not address the level of the premium increase, only the percentage used for claims and quality activities.

Likewise, insurance rate review will not prevent rate hikes. Neither the Department of Health and Human Services nor most states have the power to prevent a rate hike. For example, an article in the August 27 *Wall Street Journal*[19] reported that officials had "greenlighted" hikes in health insurance rates of more than 36 percent in Tennessee, 25 percent in Kentucky and 23 percent in Idaho. Our rate review factsheet is attached.

Anthem's Affiliation with the Blue System Raises Concerns. Anthem's affiliation with the Blue Cross and Blue Shield system raises some particular competitive concerns. An August 2015 letter[20] from Joe R. Whatley, Jr., to the Department described the Blue Cross Blue Shield Association's license agreement that prevents the individual Blue plans from directly competing against one another, and also prevents their non-Blue subsidiaries from competing even slightly vigorously against other Blue companies. The letter stated:

> Because Anthem cannot expand its non-Blues business, an evaluation of the effects of its merger with Cigna must include not only those geographic markets in which Cigna competes with Anthem, but also those geographic markets where Cigna competes (or would compete) with any other insurers. In each of those markets … Cigna can no longer compete for new business in any market unless it decreases its business by an offsetting amount in another market. The net effect is that Cigna's effectiveness as a competitor … will be impaired.

The letter may only have partially captured the extensive interconnections between Anthem and the other BlueCard members that appear likely to eliminate competition between Cigna and every Blue plan in every state. In fact, the letter may understate the coordination likely to result between Cigna and the non-Anthem Blues plans.

As a result of the folding of Cigna into the overall Blue system through Anthem's Blues affiliation, this deal may augment the already considerable power of the Blue plan in every state. The AMA data report that Blues plans tend to be the most dominant plan in virtually every state in which they operate. Because of the way in which the Blue system operates, Blues plans nationwide may now be able to control Cigna lives – particularly for BlueCard members, including national employer accounts – as their own when they negotiate with providers for rates, terms and conditions under which coverage is available to consumers. If so, this would give these Blues plans even more market power to block entry into their local markets and to constrict plan design and reimbursement rates by, for example, further narrowing provider networks available to consumers and/or driving down rates for those in the network below competitive levels and causing some to decline to participate in any network. The Blues' control over provider reimbursement would increase their ability to put new plans and those hoping to expand at a competitive disadvantage by depriving providers of the flexibility and options to work effectively with those new insurance competitors.

At a time of rising health insurance premiums, the Department and state Attorneys General should examine closely how this acquisition could increase Blue plan dominance nationwide. Blue Cross dominance has been an issue the Department has been concerned with in previous health insurance consolidations. In a speech by former Assistant Attorney General Christine Varney[21], she noted that local health plan dominance (i.e., Blue plan dominance) creates barriers to entry. And, the Department has challenged two Blue plan mergers that would have increased that dominance. Given the size and scope of this deal and the dominance of the Blue plans nationwide, the Department should thoroughly investigate how the addition of Cigna to the Blues' arrangement could further entrench that widespread dominance and decrease competition, reduce the number of participating providers and lead to higher consumer premiums.

Anthem has yet to provide a cogent explanation of how it could comply with Blues' rules *and* deploy Cigna as an effective competitor. Suggesting as Anthem did at the September 22 Senate hearing that it has two years after the deal closes to work out an arrangement surely cannot convince officials or others that the Blues' rules should not be a primary consideration in disallowing the acquisition.[22] In addition, Anthem's market segmentation argument does not alleviate the competitive concerns that arise because of the control local Blues plans will have over Cigna lives as a result of this deal. Bolstering the dominance of local Blues plans in this manner will further harm consumers and providers in virtually every state and increase what are already formidable barriers to entry in the health insurance markets in these states.

While it may have been sufficient in the past, it is unlikely that divestitures, no matter how numerous, could rescue this deal. As we noted in our letter to the Department, in "the 817 at-risk markets, over half of the lives that need to be divested reside across 368 MSAs (metropolitan statistical areas) and rural counties [where there is] no divestiture possibility that is likely to

preserve" the benefits of competition. Significantly, it has been reported that the divestitures required for two deals overseen by the Federal Trade Commission (FTC) are floundering. That is significant because the divestitures for both deals were much less numerous than those likely to be required for an Anthem/Cigna combination.[23] The report highlighted the problems the antitrust agencies face in trying to turn "smaller firms into large competitors capable of absorbing major divestitures" in an area this complex.

Further, the deal could eliminate an irreplaceable source of competition for national accounts and large regional customers. The FTC recently prevailed in a case where it found a national market despite the parties' claims the market was more segmented and localized.[24] Both Cigna and Anthem serve national accounts (large multi-state employers) and large regional customers. As recently as the first quarter of 2015, Anthem's president and CEO told investors it was "optimistic" about the 2016 outlook for national accounts and had closed on two new large accounts serving several hundred thousand lives.[25] In its second quarter 2015 earnings call with investors, Anthem's chief financial officer and executive vice president suggested its Blues affiliation was an "instrumental part" of its success with national accounts.[26]

Aetna's Acquisition of Humana Could Further Concentrate Medicare Advantage (MA) Markets Already Suffering from a Lack of Competitive Alternatives. Nearly 18 million people obtain their health insurance through MA, and that number is growing rapidly: The total MA population is up 7.3 percent from this time last year, according to the latest data from the Centers for Medicare & Medicaid Services (CMS).[27] More than 2.7 million seniors are enrolled in MA plans operated by these insurers in more than 1,000 markets that would become highly concentrated if Aetna is permitted to acquire Humana (this estimate uses the HHI). The deal would not only eliminate current competition between Aetna and Humana in the MA market, it also would eliminate the possibility of future competition between them. Humana is the second-largest MA insurer with 3.23 million members (an 11.4 percent increase over last year), and Aetna the fourth largest with 1.27 million members.[28] As recently as 2014, Aetna appeared to believe it was capable of growing its MA business substantially without this acquisition.[29]

This is particularly concerning as there is almost a complete lack of competition in MA markets, according to an August 2015 report by the Commonwealth Fund[30], which found that 97 percent of MA markets in U.S. counties are "highly concentrated." This confirms the findings of a recent report by the Kaiser Family Foundation[31] that also described MA markets as highly concentrated. That report also noted that, while the MA program has continued to grow in virtually all states, MA plans now provide less financial protection for enrollees and average out-of-pocket expenses have continued to climb; this is not an unexpected development in such highly-concentrated markets.

A somewhat perplexing new report from Avalere[32] (on which the insurers seem to base most of their arguments about "new competition" in MA) suggests that both the Commonwealth Fund and Kaiser are wrong. The report claims there is new market entry and growth, as well as diversification in MA markets. These new entrants mainly comprise a Blue plan and 15 provider-owned plans. While provider-owned plans offer seniors an excellent choice in the geographic areas they cover, they cannot begin to replace the loss of competition in more than 1,000 markets in 38 states for the 2.7 million seniors that are at risk because of this transaction. And, like any

new entrant, they can be susceptible to anticompetitive market strategies deployed by entrenched commercial insurers. Furthermore, some skepticism should be applied to any characterization of a Blue plan as a new entrant into a health insurance market; Dafny notes that the Blues have had a 10 percent share of the MA market since 2007.[33]

The Department has viewed MA as a separate product market because of its unique characteristics. Both lower out-of-pocket costs and a more extensive benefit design have distinguished it from traditional Medicare. While payments to MA plans have moderated, the financial protection and greater range of benefits offered by MA plans continue to attract seniors in large numbers, despite predictions that lowered payments would have the opposite effect.

The high barriers to market entry and lack of efficiencies present in the Anthem deal are present here as well. The remedy the Department has relied on in previous health insurance deals – a series of MA plan divestitures – is unlikely to be sufficient to remediate the likely competitive harm from this deal. The difficulty of implementing successfully this structural remedy should not be underestimated – a suitable acquirer would need to be identified in 1,083 counties in 38 states serving more than 2.7 million current Aetna and Humana members. Even if it were feasible, which it likely is not, it would be a staggering task to develop, implement and supervise these divestitures in a manner that did not further erode the competitive equilibrium in these markets and harm seniors, as well as the promise of the MA program itself.

WHY HOSPITAL DEALS ARE DIFFERENT

Hospitals' Realignment. Hospitals have shouldered much of the heavy burden of reshaping the nation's health care system to meet the laudable goals of improving quality and efficiency and making care more affordable for patients and families. And hospitals have made significant strides toward meeting all of those goals. A July 2015 study, reported in the *Journal of the American Medical Association*, described it as a "medical hat trick:"[34]

> In this comprehensive analysis of the hospital trends in the Medicare fee-for-service populations aged 65 years and older, there were marked reductions in all-cause mortality rates, all-cause hospitalization rates, and inpatient expenditures, as well as improvements in outcomes during and after hospitalization.

Unlike the insurance deals, which appear motivated by top-line profits, hospital realignment is a procompetitive response to the major forces reshaping the health care system:

- Widespread recognition, especially among those in the hospital field, of the need to replace a "siloed" health care system with a continuum of care that improves coordination and quality and reduces costs for patients;
- Changes in reimbursement models to reward value and encourage population health;
- Increased capital requirements; and
- Competition that is rapidly changing how services are delivered.

Building a Continuum of Care. Building a continuum of care demands that providers be more integrated. Integration can take many forms – hospitals, physicians, post-acute care providers and others in the health care chain can integrate clinically or financially, horizontally or vertically, and the relationships can range from loose affiliations to complete mergers – and it is happening across the country. For example, a large teaching hospital in Virginia is partnering with other hospitals in the state to form a regional health care system; a New Orleans health system is partnering with four other hospitals across the state to launch a network to provide patients with access to 25 medical facilities and more than 3,000 physicians; and hospitals in Michigan partnered to create a regional affiliation allowing a critical access hospital's patients access to the full array of services offered by the larger system. In addition, two prestigious teaching hospitals in California have teamed up with a local acute rehabilitation hospital to develop a world-class regional center for treating complex rehabilitation cases from around the nation.

Hospitals and patients benefit when hospitals realign. The most common benefits are improved coordination across the care continuum, increased operational efficiencies, greater access to cash and capital for smaller or financially distressed hospitals, and support for innovation, including payment alternatives that entail financial risk. For financially struggling hospitals, finding a partner can make all the difference. For example:

- A health system in Ohio acquired a small, community hospital in bankruptcy with closure impending; it expanded access to care in the rural area, increased technological efficiencies and saved 250 community jobs.
- An acquisition by a nearby hospital system of a hospital that was struggling financially led to it being transformed into a much-needed regional children's hospital, which provided improved access and services for area children.

Regulatory Barriers Persist for Integration. While innovative partnerships and integrative arrangements abound throughout the country, permanent arrangements, such as mergers, offer the most protection from a staggering array of outdated regulatory barriers that make integration risky when Medicare or Medicaid patients are involved. Despite the AHA having identified the five main barriers to clinical integration more than 10 years ago, to date, only one regulatory barrier has been addressed. The following barriers remain:

- Lack of antitrust guidance on clinical integration (current guidance applies only to arrangements that are part of ACOs);
- Restrictions on arrangements that base payments on achievements in quality and efficiency instead of just hours worked (Stark Law);
- Restrictions on financial incentives to physicians that could be construed as influencing care provided, even if the goal of the incentive is to adopt proven protocols and procedures to improve care (Anti-kickback law); and
- Uncertainty about how the Internal Revenue Service will view payments from tax-exempt hospitals to non-tax exempt physicians working together in clinically integrated arrangements.

It is notable that all these barriers to clinical integration had to be addressed to allow the ACO program to move forward. Yet, the federal agencies responsible for administering these laws and regulations have yet to modernize them, with one limited exception, to support even more progress toward building a continuum of care through innovative arrangements like those described above.

MOVING TO A VALUE-BASED REIMBURSEMENT SYSTEM

Increasingly, reimbursement models are being recast to compensate providers based on outcomes, not the volume of services provided. The outcomes being rewarded include keeping patients well (population health) and providing high-quality services when patients are in the hospital.

Many hospitals, health systems and payers are adopting delivery system reforms with the goal of better aligning provider incentives to achieve higher-quality care at lower costs. These reforms include forming ACOs, bundling services and payments for episodes of care, developing new incentives to engage physicians in improving quality and efficiency, and testing payment alternatives for vulnerable populations. CMS recently announced a goal of moving 30 percent of Medicare payments to alternative models of reimbursement that reward value by 2016 and to 50 percent of payments by 2018. In its announcement, CMS recognized that achieving these goals would require hospitals to "make fundamental changes in their day-to-day operations that improve the quality and reduce the cost of health care."

Hospitals have supported these efforts and often take the lead in testing and improving them. In addition, hospitals are collaborating with and learning from each other in order to improve the quality of care they deliver to patients. For example, the Health Research & Educational Trust (HRET), an AHA affiliate, was awarded a contract by CMS to support the Partnership for Patients campaign, a three-year, public-private partnership designed to improve the quality, safety and affordability of health care for all Americans. The AHA/HRET Hospital Engagement Network project helped hospitals adopt new practices with the goal of improving patient care and reducing readmissions by 20 percent. The project, which included a network of nearly 1,500 hospitals across 31 states, focused on several areas of impact and produced cost savings of $988 million through improved care. Some additional highlights include: a 61 percent reduction in early elective deliveries across 800 birthing hospitals; a 48 percent reduction in venous thromboembolism (blood clot in a vein) across 900 hospitals; and a 54 percent reduction in pressure ulcers across 1,200 hospitals.

Meanwhile, many hospitals report that it has been difficult to work with commercial insurers in moving to new payment models. We recently surveyed members of AHA's nine regional policy boards, which represent hundreds of hospitals around the nation, about their experience working with commercial insurers on new payment models. About 80 percent reported it was a challenge to work with insurers on new payment models, and more than 40 percent described it as a major challenge.

INCREASED CAPITAL REQUIREMENTS

The fundamental restructuring that CMS anticipates in response to its alternative reimbursement models will undoubtedly come with a high cost that will be particularly difficult to bear for small and stand-alone hospitals. Already, the field is under serious financial pressure from the need for capital expenditures, particularly those for health information technology (IT) and electronic health records (EHRs). In fact, the AHA estimates that hospitals collectively spent $47 billion on IT, including EHRs, each and every year between 2010 and 2013.

EHRs are essential to improving care and, consequently, succeeding in value-based reimbursement models. Every hospital is expected to meet a constantly evolving set of standards for having and using EHRs for their patients. And a portion of Medicare and Medicaid reimbursement is conditioned on EHR adoption and use. Estimates are that EHRs will cost a hospital between $20 and $200 million depending on their size. For smaller, rural and stand-alone hospitals, these costs can be ruinous without a partner to absorb some of the cost and provide the necessary technical expertise.

For many hospitals, the credit markets are already difficult to access. The most recent Fitch Rating report confirms this; starting in 2011, the profitability "metrics" for the lowest-rated hospitals have declined.[35] The lowest-rated hospitals tend to be smaller or stand-alone. The debt burden for the lowest-rated hospitals also has continued to grow, and the hospitals' operating margins are razor thin. For these hospitals, accessing the credit markets for capital improvements, including technology, will be difficult, if at all possible. Without a partner, these hospitals will continue to decline until they are forced to close their doors, with potentially devastating repercussions for the communities they serve.

NEW COMPETITION FOR HOSPITAL SERVICES

Rapid changes in the health care market are providing consumers with an increased array of options for their health care, including services that hospitals provide.

CVS, Walgreens and Wal-Mart, among others, are changing where consumers go for their health care needs. The retailers offer an array of health care services, including primary care, immunizations, blood pressure monitoring and routine blood tests, all of which were formerly available only in a doctor's office or hospital outpatient clinic or emergency room. Meanwhile, many of the retailers plan to provide even more sophisticated care and services at their thousands of convenient locations. These developments challenge hospitals to become more integrated with physicians and other providers so that they too can offer convenient and more affordable care that is attractive to patients.

In addition, telehealth promises to revolutionize how an incredible array of health care services are provided to consumers and to change the competitive landscape entirely. Telehealth is already delivering services as different as dermatology and mental health to patients across town and across the country. A hospital in Arlington, Va., has an arrangement with the Mayo Clinic, which is based in Rochester, Minn., that allows its patients access to Mayo's expertise without

leaving the neighborhood. In addition, a hospital system in California was able to cover its need for physician intensivists at one of its satellite facilities using mobile telehealth devices instead of hiring new doctors, with positive clinical and patient satisfaction outcomes. Increasingly, patients are able to consult doctors using their computers, laptops and smartphones, and this is becoming a more common expectation of patients when they seek care. For their part, insurers too are increasingly relying on telehealth to reduce costs and meet network adequacy requirements. All of this changes the competitive landscape for hospitals. Now, competitors for even specialized services do not have to be in the same neighborhood, city or state to connect with patients who might otherwise have sought care at their local hospital.

The rapid growth of telehealth illustrates how quickly the competitive landscape can change for hospitals and the importance of having adequate financial resources and access to capital. Without those resources, hospitals cannot keep up with the demands of new technology or the opportunities they present.

CONCLUSION

Consumers and the entire health care system are threatened by the potential consequences of the unprecedented consolidation that would result from Anthem's acquisition of Cigna and Aetna's acquisition of Humana. These health insurance deals, which would affect at least one form of health insurance in every state, could mean fewer choices for consumers for commercial insurance and MA plans, narrower networks of providers in what few choices remain and higher prices for premiums or more out-of-pocket costs. The deals also could diminish insurers' willingness to be innovative partners with providers, as well as jeopardize the momentum hospitals have led to improve quality and efficiency while making care more affordable for patients and families.

Some have compared the insurance deals to those in the telecommunications arena because of their size and the enduring ability to contort the market and harm consumers. The Department was ready to challenge the telecommunications deals, and it also should be ready to challenge the insurance deals, if, as we expect, its intensive investigation confirms that these transactions threaten the growth and vitality of our health care system and the health and welfare of consumers across the nation.

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[1] Joe R. Whatley, Jr., letter to the Honorable William Baer, August 13, 2015.
[2] Testimony of Professor Leemore S. Dafny, Ph.D., Professor of Strategy, Kellogg School of Management Northwestern University, before the Senate Subcommittee on Antitrust, Competition Policy, and Consumer Rights on "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?" (Dafny Testimony) September 22, 2015 at 3.
[3] Dafny Testimony at 16.
[4] Dafny Testimony at 16.
[5] AHA letter to the Honorable William Baer, August 5, 2015, and AHA letter to Baer and Secretary Sylvia Burwell, September 1, 2015, *www.aha.org/letters*

[6] Competition in Health Insurance A comprehensive study of U.S. markets, American Medical Association, 2015 Update, https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product_id=prod2680007&navAction=push#usage-tab.
[7] Wang E, Gee G. Larger Issuers, Larger Premium Increases: Health insurance issuer competition post-ACA. *Technology Science*. 2015081104. August 11, 2015, http://techscience.org/a/2015081104.
[8] AHA letter to the Honorable William Baer, August 5, 2015.
[9] 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.
[10] Tough Going for Co-Ops, New York Times, September 15, 2015, http://www.nytimes.com/2015/09/16/business/health-cooperatives-find-the-going-tough.html?_r=0
[11] Tough Going for Co-Ops, New York Times, September 15, 2015.
[12] Tough Going for Co-Ops, New York Times, September 15, 2015.
[13] This $1.5 billion Startup is Making Health Insurance Suck Less, Wired, March, 20, 2015, http://www.wired.com/2015/04/oscar-funding/.
[14] Tough Going for Co-Ops, New York Times, September 15, 2015.
[15] Dafny Testimony at 12.
[16] Dafny Testimony at 16.
[17] Testimony of Professor Thomas L. Greaney, Before the House of Representatives Subcommittee on Regulatory Reform, Commercial and Antitrust Law, September 10, 2015.
[18] Dafny Testimony at 3.
[19] Insurers Win Big Health-Rate Increases, Wall Street Journal, August 27, 2015, http://www.wsj.com/articles/insurers-win-big-health-rate-increases-1440628848.
[20] Whatley BCBS Letter to DOJ.
[21]Remarks of Christine Varney, then Assistant Attorney General of the DOJ's Antitrust Division, at a joint American Bar Association/American Health Lawyers Association Antitrust in Healthcare Conference, May 24, 2010, available at http://www.justice.gov/atr/speech/antitrust-andhealthcare
[22] Remarks by Anthem's president and CEO during Senate hearing on September 22, 2015.
[23]Reporting on divestitures ordered in the car rental and grocery store industries. Divestitures required were 58 on-airport locations and a line of business for the Hertz deal and 168 supermarkets in 130 locations for Albertsons. http://pipeline.thedeal.com/tdd/ViewArticle.dl?s=dd&id=13291361&cmpid=em:DA091715#ixzz3m1SYWNdc
[24] *FTC v. Sysco Corp*, (D.D.C.) June 23, 2015 at https://www.ftc.gov/system/files/documents/cases/150623syscomemo.pdf
[25] Anthem Quarter 1 Earnings Call with Investors, April 29, 2015, http://www.thestreet.com/story/13131183/1/anthem-antm-earnings-report-q1-2015-conference-call-transcript.html.
[26] Anthem Quarter 2 Earnings Call with Investors, July 29, 2015, http://phx.corporate-ir.net/External.File?item=UGFyZW50SUQ9NTg4NjExfENoaWxkSUQ9Mjk2ODg1fFR5cGU9MQ==&t=1.
[27] Medicare Advantage membership nearly 18 million ahead of annual enrollment, Modern Healthcare, September 17, 2015 (Modern).
[28] Modern.
[29] AHA letter to the Honorable William Baer and Secretary Burwell, September 1, 2015 (see chart page 16).
[30] Brian Biles, Giselle Casillas, and Stuart Guterman, Competition Among Medicare's Private Health Plans: Does It Really Exist?, The Commonwealth Fund August 2015, www.commonwealthfund.org/publications/issue-briefs/2015/aug/competition-medicare-private-plans-does-it-exist.
[31] Gretchen Jacobson, Anthony Damico and Marsha Gold, Kaiser Family Foundation Issue Brief, Medicare Advantage 2015 Spotlight: Enrollment Market Update, June 30, 2015, http://kff.org/medicare/issuebrief/medicare-advantage-2015-spotlight-enrollment-market-update/.
[32] New Market Entrants: Growth and Diversification in U.S. Health Insurance, Avalere, September 2015.
[33] Dafny Testimony at 7.
[34] 'Jaw-dropping': Medicare deaths, hospitals AND costs reduced, USA Today, July 28, 2015. Reporting on "Mortality, Hospitalizations, and Expenditures for the Medicare Population Aged 65 Years and Older, 1999-2013," Krumholz, Nuti, Downing, Normand & Wang, JAMA, July 28, 2015, Vol. 312, No. 4.
[35] FitchRatings, 2015 Medium Ratios for Nonprofit Hospitals and Health Systems, Special Report, August 10, 2015.

Why Medical Loss Ratio Requirements Aren't a Defense to Further Health Plan Consolidation (Commercial Market)

The Affordable Care Act (ACA) imposes a federal minimum Medical Loss Ratio (MLR) requirement on fully-insured health insurance sold in the individual, small group and large group markets. The MLR is a measure of how much of each premium dollar (less taxes, licensing and regulatory fees) goes to pay for medical claims and activities to improve quality versus plan administration, marketing and insurer profit. The higher the MLR, the more value the policyholder receives for each dollar paid as premium to the insurer. ***A minimum MLR standard does not, however, limit the amount of premium that an insurer may charge for its health insurance plans.***

Background. Health insurers are required to publicly report MLRs each year in each state in which they operate. The federal minimum MLR standard for large insured group health insurance is 85 percent; for individual and small group insurance, it is 80 percent.[1] Through 2015, a state may define a large group as one with over 50 members; thereafter, a large group will be defined as having more than 100 members. Insurers of plans that do not meet these minimum required MLR thresholds must rebate excess premium amounts to their policyholders.

These provisions were established by the ACA with the intention of improving the value and transparency of health insurance coverage. As a result of the rebate requirement, consumers in the fully insured commercial market have recouped millions of dollars in excess premiums. However, *administrative and marketing expenses continue to account for a significant portion of premiums*. And despite the application of the MLR requirements and premium rebates beginning in 2011, insurers' profit margins experienced less than a 0.2 percentage point decline between 2011 and 2013, with the losses occurring in the individual market offset by increases in the small and large group markets.[2] In both 2013 and 2014, the performance of the large national insurers such as Aetna, UnitedHealth and Anthem was favorable, with profit margins exceeding 3.5 percent.[3]

Moreover, the ACA's MLR standards are not applied to all health coverage. The federal government estimated in 2010 that the MLR standards would protect up to 74.8 million insured Americans,[4] which was less than 40 percent of people with private health insurance that year.[5] Plans that are not subject to the MLR requirements include those that are fully- or partially self-insured, which comprise well over 50 percent of private sector employees. Also exempt are dental-only, accident-only and other "excepted benefits," as well as expatriate plans. In addition, a one-year deferral from the MLR is available to insurers that would otherwise be subject to the

MLR limits but have a high proportion of new plans (representing at least half of their business in a given state). [6]

Why the MLR Doesn't Support Further Health Plan Consolidation. The MLR requirements have already surfaced as a defense to the proposed acquisitions of Cigna by Anthem and of Humana by Aetna. The argument to the Department of Justice's Antitrust Division (DOJ) and other federal and state regulators would be that the insurers are constrained from raising prices to consumers because of the MLR margin (profit or net revenue) restrictions applicable in both the commercial and Medicare Advantage markets. This argument is unavailing and should be rejected for the several principle reasons:

1) **The ACA's MLR requirements apply to less than 50 percent of Americans under age 65 with health insurance coverage.**

As noted above, self-insured (self-funded) health plans, including self-insured association and trust plans, are not subject to the MLR standards, which means that nationwide nearly three out of every five workers are not in plans for which the MLR requirement applies.[7] Although the rate of self-insurance varies across the 50 states and the District of Columbia, in almost all states, more than 50 percent of private sector employees are covered by self-insured plans that are exempt from the MLR requirements.[8] Providing administrative services and stop-loss coverage to group health plans sponsored by employers and unions makes up a significant segment of revenues for companies such as Anthem, Aetna, and Cigna. Thus, even if the ACA's MLR requirements acted as some constraint on premiums for their fully insured lines of business, they would be able to raise the fees charged for services provided to self-funded customers. These increased fees would be passed along to employees as increased premiums or cost-sharing.

2) **The rules for reporting MLRs provide for a relatively high level of aggregation that may mask wide differences in the return on premium for an insurer's different health insurance products.**

The ACA's MLR is not based on each insurer's policy, but on an insurer's annual aggregate performance within each market (individual, small group, or large group) and state. A loss ratio computed separately for an insurer's specific book of business would be subject to more volatility due to unexpected utilization changes than would a measure across the insurer's entire book of business, for example. Yet the broader application of the measure, as required by the ACA's implementing regulations, masks potentially significant variation by market or type of plan. As such, the MLR allows insurers to offer products that do not meet the minimum MLR threshold.

3) **The MLR does not address the level of a premium. It only establishes that a minimum percentage of that premium must be used for medical claims and quality enhancing activities.**

Here are a few examples of ways that insurers can increase premiums while still meeting existing MLR standards, using an 85 percent illustrative standard and a starting premium of $1,000. *For simplicity, the example assumes that the MLR is reported for a specific health plan offered by an insurer but as discussed above, in fact, the MLR would be reported across all insured health plans offered by the insurer in its individual, small group or large group markets in a state.*

A. Plan is at MLR in Time 1

In this case, an insurer could raise the plan's premium by any amount. It would, however, need to ensure that the plan maintains its minimum MLR of 85 percent. In this example, it increases its premium by $100, increasing both its medical claims spending as well as other expenses to continue to comply with the MLR standard.

	Time 1	Time 1 Loss Ratio	Time 2	Time 2 Loss Ratio
Premium	$1,000		$1,100	
Payments for medical claims and quality activities	$850	85%	$935	85%
All other expenses	$150		$165	

B. Plan is above minimum MLR in Time 1

In this case, the plan is not impacted by the minimum MLR, since it already meets the standard. This plan can raise its premium by $60, potentially keeping all of it as profit, before becoming constrained by the MLR policy.

	Time 1	Time 1 Loss Ratio	Time 2	Time 2 Loss Ratio
Premium	$1,000		$1,060	
Payments for medical claims and quality activities	$900	90%	$900	85%
All other expenses	$100		$160	

C. Plan is below minimum MLR in Time 1

In this case, the plan is not meeting the MLR standard, so it must devote more of its premium to medical claims or quality activities. It can do this by:

- Raising spending on claims until such spending reaches the minimum standard, in this example, by raising premiums by $335.
- Providing a rebate of $50 to beneficiaries (the difference between the minimum standard of 85% or $850 and current spending on claims or $800), or
- Keeping the premium at its current level, and raising spending on medical claims (for example, by increasing provider payment rates) while simultaneously reducing administrative costs or profit.

	Time 1	Time 1 Loss Ratio	Time 2	Time 2 Loss Ratio
Premium	$1,000		$1335	
Payments for medical claims and quality activities	$800	75%	$1,135	85%
All other expenses	$200		$200	

The examples illustrate that there are many scenarios in which an insurer can raise rates that are not constrained by the current MLR requirements. A future administration or Congress also could alter the MLR requirements to make it even easier for plans to meet the regulatory criteria and still raise prices for consumers.

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[1] Department of Health and Human Services, Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule, *Federal Register*, December 1, 2010. Also note that the ACA gives states flexibility to impose higher minimum MLR requirements. At this point, some states do impose different (more rigorous MLR requirements than apply under federal law and regulations. Congressional Research Service, 2015. Also, HHS may, upon application, adjust the MLR standard in the individual market in a state if the Secretary determines an 80% standard would destabilize the individual market in that state. The Secretary in fact granted waivers to 7 out of 17 states that applied for waivers of the federal MLR standards for their individual markets for the years 2011-2013 on the basis that the federal minimum threshold could lead to de-stabilizing those markets. The states are GA, IA, KY, ME, NE, NH and NC. Department of Health and Human Services, "2011 Issuer MLR Rebate Estimates in States that Applied for an MLR Adjustment," Table of States Requesting Rebates, http://cciio.cms.gov/programs/marketreforms/mlr/rebateestimates.html.

[2] McCue, Michael J. and Mark A. Hall, The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 3, The Commonwealth Fund, March 2015; http://www.commonwealthfund.org/~/media/files/publications/issuebrief/2015/mar/1808_mccue_med_loss_ratio_year_3_rb.pdf?la=en

[3] Mark Farrah Associates, *Enrollment Gains and Favorable Profits for Health Insurance Leaders in 2014*, May 15,2015, http://www.markfarrah.com/healthcare-business-strategy/Enrollment-Gains-and-Favorable-Profits-for-Health-Insurance-Leaders-in-2014.aspx

[4] Centers for Medicare & Medicaid Services, *Medical Loss Ratio: Getting Your Money's Worth on Health Insurance*, www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/medical-loss-ratio.html; see also the Interim Final Rule impact statement at 75 FR 74896

[5] Calculated as 74.8 million/Population in 2010 with private health insurance. Percentage of U.S. population with private health insurance from http://www.census.gov/prod/2011pubs/p60-239.pdf. Total population from http://www.census.gov/quickfacts/table/PST045214/00

[6] Centers for Medicare & Medicaid Services, Medical Loss Ratio Requirement Under the Patient Protection and Affordable Care Act, Final Rule, May 16, 2012; 77 FR 28790; CMS, CCIIO, *May 24, 2012 FAQ*, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mlr-guidance-5-24-2012.pdf

[7] Kaiser Family Foundation and HRET, *2014 Employer Health Benefits Survey* http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report

[8] These rates are rounded to the nearest full percentage. AHRQ, Medical Expenditure Panel Survey, Table II.B.2.b.(1)(2014) Percent of private-sector enrollees that are enrolled in self-insured plans at establishments that offer health insurance by firm size and State: United States, 2014, http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2014/tiib2b1.pdf

American Hospital Association®

Why "Rate Review" of Hikes in Health Insurance Isn't a Defense to Further Health Plan Consolidation (Commercial Market)

States carry out varying degrees of review of health insurers' rates. Some states review rates and approve them prior to the rates going into effect. Other states require insurers to simply file a rate with the department before the insurer implements it (file and use). Some states have no regulatory oversight of rates at all. The Affordable Care Act (ACA) established a rate review requirement for health insurance products with rate increases of 10 percent or more in a year. **The federal requirement for review does not, however, include the authority to reject rates.** Reviews are conducted either by states or by the federal government through the Department of Health and Human Services (HHS).

Background. The ACA requires that the HHS Secretary, in conjunction with the states, annually review "unreasonable increases in premiums for health insurance coverage." Rates for health insurance products that increase by 10 percent or more (or exceed a state-specific threshold) must be subject to a review to determine if the rates are excessive, unjustified or unfairly discriminatory.

Forty-four states conduct their own rate reviews. As part of that process, they must post on their websites (or provide links to) rate filings under review or preliminary justifications, seek public comment on proposed rate increases, and report the results of their rate reviews to HHS. States' reviews may or may not reject excessive rates from being implemented based on whether the state has the authority to disallow them under state law, and whether the state acts on that authority.

In five states, where HHS has determined that there is not an effective rate review program, HHS conducts the review. If HHS finds that a rate increase is unreasonable, it posts that determination on its website and informs the insurer of the determination. The insurer is then required to either notify HHS that it will not implement the rate increase or provide a justification for the rate increase to HHS and post the justification to its website. The carrier could still choose to implement the proposed increase. HHS does not have the authority to disallow it but may take recommendations by state regulators about patterns or practices of excessive or unjustified rate increases into account in determining which plans may be offered as qualified health plans through health insurance exchanges.[1]

The rate review requirement applies to all insurance products sold in the individual and small-group markets except for grandfathered health plans. (Small groups for this purpose are defined as those with fewer than 50 employees until 2016 when that threshold rises to 100.)

Why Rate Review Doesn't Support Further Health Plan Consolidation. The rate review requirements could be one of the defenses the insurers' (Anthem/Cigna and/or Aetna/Humana) mount to charges that these acquisitions will provide them with additional market power to increase rates by unreasonable amounts. This defense is unavailing for the simple reason that the ACA's rate review provisions are not effective to prevent unreasonable increases of less than 10 percent, much less those over 10 percent. The weaknesses of the federal rate review process for the commercial market includes the following points:

1. **The ACA's rate review requirements apply to a small minority of Americans with private health insurance coverage.**

Federal rate review is not universal. It only applies to non-grandfathered plans offered in the small and individual markets and, in most states, to non-association sponsored health plans. In 2011, when HHS issued the final rate review rule, it estimated that 35 million people would be covered by products subject to rate review. In that year, that represented about 17 percent of the commercial market for health insurance.[2]

2. **The federal rate review requirements have limited effectiveness.**

The federal requirements do not provide HHS with the authority to reject excessive rates nor to require states to give such authority to their Departments of Insurance. Nor do they pre-empt states' own rate review laws or procedures. As a result, the wide variation in the effectiveness of states' processes has continued post-ACA. For example, state processes continue to vary with respect to the authority each state's law gives the insurance departments to deny or turn back rates.[3] As noted above, however, HHS *may* take into account recommendations by state regulators about patterns or practices of excessive or unjustified rate increases in determining which plans will be offered as qualified health plans through exchanges (assuming there is an alternative plan to offer).

3. **Even in states that have the authority to reject rate increases, they do not always do so.**

The climate in some states may not support strong rate review even if the insurance commissioner/department has the authority to turn back rates.[4]

4. **The public disclosure aspect of the rate review process is not fully functioning as intended.**

HHS does not have the authority to reject rates; the only influence it may have is to publically pressure insurers to re-evaluate. This dubious strategy assumes a degree of price transparency that is not yet fully operational and may never be. Some states and HHS allow a trade secret exemption for insurers that wish to keep their rates from the public and, as a result of the exemption, HHS withheld 2015 rate filings from public view.[5] Further, those filings that are publically disclosed are often not easy for consumers to access or understand.

[1] 45 CFR Part 154, Subparts B and C; https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016DraftLettertoIssuers12-19-2014.pdf

[2] Final Rule with Comment Period: Rate Increase Disclosure and Review, 76 *Federal Register* 29964 - 29988, http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf

[3]Available at http://consumersunion.org/wp-content/uploads/2014/04/Exhibit-A-State-List-Public-Participation.pdf; http://www.healthcaredive.com/news/state-rate-regulation-is-there-one-future-or-50/391431/

[4] New York Times, Health Insurers Raise Some Rates by Double Digits, January 5, 2013, http://www.nytimes.com/2013/01/06/business/despite-new-health-law-some-see-sharp-rise-in-premiums.html?_r=0

[5]Health Affairs blog, http://healthaffairs.org/blog/2014/12/24/health-insurance-rate-setting-time-to-raise-the-bar-and-lift-the-veil-of-secrecy/; The Hill, Congress Blog, June 16, 2014 http://thehill.com/blogs/congress-blog/healthcare/209330-aca-addresses-our-long-history-of-premium-rate-hikes