

DEPARTMENT OF INSURANCE

EXECUTIVE OFFICE
300 CAPITOL MALL, SUITE 1700
SACRAMENTO, CA 95814
(916) 492-3500
(916) 445-5280 (FAX)
www.insurance.ca.gov



June 23, 2016

The Honorable Loretta E. Lynch
Attorney General of the United States
United States Department of Justice
950 Pennsylvania Avenue, N.W.
Washington, D.C. 20530

Ms. Renata B. Hesse
Principal Deputy Assistant Attorney General
United States Department of Justice
950 Pennsylvania Avenue, N.W.
Washington, D.C. 20530

RE: Proposed merger of Aetna Inc. and Humana, Inc.

Dear Attorney General Lynch and Principal Deputy Assistant Attorney General Hesse:

I am writing regarding the proposed acquisition of Humana, Inc. (“Humana”) by Aetna Inc. (“Aetna”). I lead the California Department of Insurance. This letter provides the results of the evaluation of the proposed merger by the California Department of Insurance, including the evidence obtained during a hearing I held on this matter.

As California’s Insurance Commissioner, an independent regulatory office in California, I am concerned with all factors that would impair competition in the California health coverage market.¹ California’s insurance market is the largest insurance market in the United States. Insurers in California collect \$259 billion in premium annually. California also has the largest health insurance market in the United States. Health insurers and managed care plans collect \$122.9 billion in premium annually from Californians.² As Insurance Commissioner, and chair of the Western Zone of the National Association of Insurance Commissioners (NAIC),³ I

¹ The California Department of Insurance regulates indemnity, Exclusive Provider Organization (EPO), and Preferred Provider Organization (PPO) coverage in California, except for some PPO coverage provided by members of the Blue Cross/Blue Shield Association, which because of a historical exception are regulated by the California Department of Managed Health Care, which also, under the executive authority of the Governor, regulates managed care organizations (health care service plans, aka HMOs).

² Josh Cothran, *The Private Insurance Market in California, 2013* (Cal. Health Care Found. Feb. 2015), <http://www.chcf.org/publications/2015/02/data-viz-health-plans>.

³ The NAIC Western Zone comprises the following states: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Texas, Utah, Washington, Wyoming. Nat’l Ass’n of Ins. Comm’rs, *2016 Members by Zones* (May 2, 2016), http://www.naic.org/documents/members_by_zone.pdf.

monitor changes and proposed changes in the insurance industry, such as the pending health insurer mergers, that might directly affect California and its residents. However, I also monitor and review regional, national, and international changes in the insurance industry that primarily affect markets outside California. The California Department of Insurance is routinely called upon for its expertise on national insurance market and regulatory issues outside of California.

Over the past year, there have been three proposed acquisitions, two of which are of significant competitive concern. The first merger, that of Centene and Health Net, involved a company focused on government contracts (Centene) acquiring a struggling company active in the commercial market (Health Net). I approved that acquisition after imposing stringent requirements to require the combined entity to remain in the commercial market and to strengthen the combined entity as a viable competitor in the commercial market. The second proposed merger, that of Anthem and Cigna, posed significant and immediate competitive concerns for Californians, as I conveyed to you in my June 16, 2016 letter.

The third proposed merger under review by the Department of Insurance, and the subject of this letter, is the proposed merger of Aetna and Humana. This merger poses immediate competitive concerns nationwide, based on evaluation of regional markets using the factors recited in the Department of Justice (DOJ) and Federal Trade Commission (FTC) Horizontal Merger Guidelines (Merger Guidelines).⁴ Similarly, the merger poses competitive issues in the Medicare Advantage (MA) market in California. Most significant for Californians, however, is that the proposed merger of Aetna and Humana will remove a potential competitor from an already concentrated commercial market. In an era where the largest insurers exacerbate barriers to entry by consolidating insuperable market power, the loss of a national insurer with the resources and expertise needed to expand into a heavily consolidated market would be a substantial loss for Californians. The same anticompetitive impact is true in markets outside of California. With only a few players left on the field, sending a strong player into the locker room has substantial anticompetitive impact.

I urge that, in light of the recent trend towards consolidation in the health insurance industry, the Department of Justice not evaluate each of these transactions in a vacuum but, rather, consider the overall anticompetitive impact of these consolidations in their totality. This is especially important in light of the market dominance of the companies involved. The proposed Aetna-Humana merger would combine the third and fifth largest health insurers by market value in a setting where the second and fourth largest health insurers by market value (Anthem and Cigna) have also proposed a merger.⁵

⁴ U.S. Dep't of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines* (Aug. 19, 2010) [hereinafter *Horizontal Merger Guidelines*], available at <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>.

⁵ Forbes, *The Biggest Health Insurers in the U.S.*, <http://www.forbes.com/pictures/emgm45e1e1/the-biggest-health-insur/> (last visited June 21, 2016).

I. BACKGROUND: THE AETNA-HUMANA MERGER HEARING

I held a public hearing regarding the proposed merger on April 27, 2016. Francis S. Soistman, Executive Vice President and Head of Government Services, testified for Aetna, and Jaewon Ryu, M.D., Vice President, Health Services Segment and President, Integrated Care Delivery, testified for Humana, Inc. Representatives of consumer groups, medical providers, and community organizations also testified.⁶ I also received written public comment. Further, my Department and I reviewed multiple studies and published articles regarding the impact of health insurance mergers, and the Aetna and Humana merger in particular.

The testimony, comments, studies and other information in the public record convince me that, in addition to removing an important potential competitor from the marketplace, the enhanced market power of a merged Aetna and Humana will have an anticompetitive effect in a number of regions. The combined entity will be able to increase premiums, decrease the quality of care provided to its members, and reduce access to crucially needed insurance products. Further, the merger will increase the oligopsony power of the combined entity in purchasing the services of healthcare providers, thus likely decreasing the quality of services. Accordingly, I oppose the proposed merger of Aetna and Humana and strongly recommend that the United States Department of Justice challenge this transaction.

II. THE MERGER WILL SUBSTANTIALLY LESSEN COMPETITION

A. *The Merger Would Significantly Increase Concentration Across Product Types in Multiple States and MSAs*

A report by the American Medical Association (AMA) presented to the U.S. House of Representatives' Committee on the Judiciary, Subcommittee on Regulatory Reform, Commercial and Antitrust Law, provided a Herfindahl-Hirschman Index (HHI) market concentration analysis of the effects of the merger by state and metropolitan statistical area (MSA).⁷ The AMA examined three product markets for the sale of insurance—health maintenance organizations, preferred provider organizations, and point-of-service plans (HMO, PPO and POS), separately and together. Based on the Merger Guidelines, the Aetna-Humana post-merger HHIs and HHI increases would result in determinations of “presumed likely to enhance market power” or “potentially raise significant competitive concerns and often warrant scrutiny” in numerous MSAs for each of these product markets in multiple states.

⁶ The hearing transcript is available at <http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/Condensed-Transcript-Aetna-Humana-hearing-April-27-2016.pdf>.

⁷ *Healthy Competition? An Examination of the Proposed Health Insurance Mergers and the Consequent Impact on Competition: Hearing Before the Subcomm. on Regulatory Reform, Commercial and Antitrust Law of the H. Comm. on the Judiciary*, 114th Cong. 92-101 (Sept. 29, 2015) (statement of Andrew Gurman, President-Elect, American Medical Association), available at https://judiciary.house.gov/wp-content/uploads/2016/02/114-47_96274.pdf.

1. The HMO+PPO+POS Market:

- a. The markets in 15 MSAs in 7 states would become highly concentrated (HHI >2500) with an HHI increase over 200, and thus the merger would be “presumed likely to enhance market power.”⁸
- b. The markets in 43 MSAs in 14 states would become either highly concentrated with HHI increases of 100-200, or moderately concentrated (HHI 1500-2500) with HHI increases over 200, and thus the merger would “potentially raise significant competitive concerns and often warrant scrutiny.”⁹

2. The HMO Market:

- a. The markets in 23 MSAs in 7 states would become highly concentrated with an HHI increase over 200, and thus the merger would be “presumed likely to enhance market power.”¹⁰
- b. The markets in 3 MSAs in 2 states would become either highly concentrated with HHI increases of 100-200, or moderately concentrated with HHI increases over 200, and thus “potentially raise significant competitive concerns.”¹¹

3. The PPO Market:

- a. The markets in 36 MSAs in 17 states would become highly concentrated with an HHI increase over 200, and thus the merger would be “presumed likely to enhance market power.”¹²
- b. The markets in 40 MSAs in 12 states would become either highly concentrated with HHI increases of 100-200, or moderately concentrated with

⁸ The number of MSAs in each of the 7 states that will become highly concentrated as a result of the proposed merger is: FL-3; GA-1; IL-1; KY-3; OH-2; TX-3; UT-2. *Id.* at 94 tbl.3.

⁹ The number of MSAs in each of the 14 states that will become either highly or moderately concentrated as a result of the proposed merger is: AZ-1; FL-4; GA-4; IL-4; IN-1; KY-2; LA-3; MS-1; OH-1; TN-2; TX-13; UT-1 WI-5; WV-1. *Id.* at 95-96 tbl.4.

¹⁰ The number of MSAs in each of the 7 states that will become either highly concentrated as a result of the proposed merger is: FL-10; GA-3; IL-2; MO-1; OH-3; TN-1; TX-3. *Id.* at 96-97 tbl.6.

¹¹ The number of MSAs in each of the 2 states that will become either highly or moderately concentrated as a result of the proposed merger is: FL-2; IL-1. *Id.* at 97 tbl.7.

¹² The number of MSAs in each of the 17 states that will become either highly concentrated as a result of the proposed merger is: CO-2; FL-4; IL-1; IN-1; KS-1; KY-3; LA-2; MO-3; MS-1; OH-1; TX-8; UT-4 WI-4; WV-1. *Id.* at 98-99 tbl.10.

HHI increases over 200, and thus the merger would “potentially raise significant competitive concerns and often warrant scrutiny.”¹³

These HHI and HHI increase levels, together with relatively high entry barriers, increase the oligopolistic nature of these markets and raise a reasonable probability of coordinated anticompetitive conduct by market participants.¹⁴

B. Multiple Studies Demonstrate that the Merger Would Substantially Increase Aetna-Humana’s Market Power in the Highly Concentrated Medicare Advantage Market in Almost All Counties

A Commonwealth Fund study found that 97% of the counties in the U.S. (2,852 out of 2,933) had Medicare Advantage (MA) markets that were highly concentrated (HHI >2,500).¹⁵ Those counties have 77% of the country’s MA enrollment (84% of all Medicare recipients). Another 80 counties, with 22% of the country’s MA enrollees (15% of all Medicare recipients) were moderately concentrated (HHI = 1,500 – 2,500). In the 100 counties with the most Medicare beneficiaries (47% of MA enrollees and 38 percent of Medicare recipients), 81% lack a competitive MA market, with three insurer groups controlling approximately two-thirds of the markets in those counties.

A July 2015 report by the Kaiser Family Foundation (KFF) focused on the anticompetitive effects that the Aetna-Humana merger would have on the MA market in numerous states and counties throughout the country.¹⁶ The report noted that approximately 17 million Medicare recipients, about one-third of all Medicare beneficiaries, are enrolled in MA plans. It found that the dominant insurers in the highly concentrated MA markets are often Aetna and Humana (along with UnitedHealthcare (UHC)). A merged Aetna-Humana would cover 26% of all MA enrollees in the country, more than any other insurer (followed by UHC with 20%). The report also found:

- Aetna-Humana together would cover 50% or more of all MA enrollees in 10 states, and at least two-thirds of all enrollees in five states (KS, LA, MS, VA, and WV).

¹³ The number of MSAs in each of the 12 states that will become either highly or moderately concentrated as a result of the proposed merger is: AZ-1; CO-4; FL-5; IL-4; IN-2; KS-1; LA-4; MO-1; MS-1; TN-1; TX-11; WI-5; WV-1. *Id.* at 99-100 tbl.11.

¹⁴ There would not be increased concentration in the POS market, except in two MSAs in GA. *Id.* at 101 tbls.12 & 13.

¹⁵ Brian Biles et al., *Competition Among Medicare’s Private Health Plans: Does It Really Exist?* (The Commonwealth Fund Aug. 2015), available at <http://www.commonwealthfund.org/publications/issue-briefs/2015/aug/competition-medicare-private-plans-does-it-exist>.

¹⁶ Gretchen Jacobson et al., *Data Note: Medicare Advantage Enrollment, by Firm, 2015* (Kaiser Family Found. July 15, 2015), <http://kff.org/medicare/issue-brief/data-note-medicare-advantage-enrollment-by-firm-2015/>; see also H.E. Frech, III, *Comments on Selected Issues re: The Proposed Mergers of Anthem and Cigna and Aetna and Humana* (May 19, 2016), available at <http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/FrechReport-FINAL-051716-CA-002.pdf>.

- Humana alone had over half of the MA market in five states (KY, LA, MS, VA, and WV). In two of those states (MS and WV), it had more than two-thirds of MA enrollees. Aetna had 25% or more of MA enrollees in eight states (AK, DE, IA, KS, ME, MO, NE, and NJ).
- Aetna-Humana would have over 50% of the MA market in 39 counties.
- In many of the states in which Aetna-Humana would have a substantial market share (35%+), another insurer (usually UHC) would also have a substantial market share.

The American Hospital Association (AHA) performed an HHI analysis for counties throughout the country using 2015 MA enrollment data from the Centers for Medicare and Medicaid Services (CMS). In a September 1, 2015 letter to the DOJ Antitrust Division and HHS Secretary Sylvia Burwell, the AHA concluded: “Aetna and Humana today provide health care coverage through Medicare Advantage for more than 4.3 million people. More than 2.7 million of these seniors—almost two-thirds of both companies’ enrollees—live in relevant geographic markets that are or will be highly concentrated and in which the HHI increase will be at least 100 points.”¹⁷ As the AHA explains, a county or parish level analysis is best regarding the competitive effects of a merger on Medicare Advantage since “CMS approves Medicare Advantage plans on a county-by-county basis, and the vast majority of seniors may only enroll in a Medicare Advantage plan in the county in which they live.”

The AHA looked at counties where both Aetna and Humana had MA members; in such counties, the post-merger HHI was at least 2,500, and the merger produced an HHI increase of at least 100 points. In 1,083 counties, the merger would increase the HHI by at least 100 points and the post-merger HHI would exceed 2,500. In 924 of those counties, the merger would increase the HHI by more than 200 points.¹⁸

With respect to California, the health care consulting firm of Cattaneo and Stroud concluded that the combination of Aetna and Humana would reduce competitiveness in eight California counties in the Medicare Advantage market.¹⁹

¹⁷ Letter from Melinda Reid Hatton, Senior Vice President and General Counsel, American Hospital Association, to William Baer, Assistant Attorney General, U.S. Department of Justice, Antitrust Division 16 (Sept. 1, 2015), available at <http://www.aha.org/advocacy-issues/letter/2015/150901-let-hatton-burwell-baer.pdf>.

¹⁸ *Id.* at 15.

¹⁹ Cattaneo & Stroud, Inc., *Before & After Results of the Proposed California HMO Acquisitions* (Aug. 24, 2015), http://cattaneostroud.com/wp-content/uploads/2015/04/Effect_of_Proposed_Calif_HMO_Acquisitions.pdf. Cattaneo and Stroud presented its analysis to the Financial Solvency Standards Board of the California Department of Managed Health Care. Aetna disputes these findings.

C. The Aetna-Humana merger will harm consumers

1. Premiums Will Increase

The proposed merger of Aetna and Humana will likely result in higher health insurance premiums for consumers. The studies which demonstrate this probable result were summarized in the September 22, 2015 testimony of Dr. Leemore S. Dafny before the United States Senate Judiciary Committee, Subcommittee on Antitrust, Competition Policy, and Consumer Rights:²⁰

There are a number of studies documenting lower insurance premiums in areas with more insurers, including on the state health insurance marketplaces,^[21] the large group market (self- and fully-insured combined),^[22] and Medicare Advantage.^[23] A recent study suggests premiums for employer-sponsored fully-insured plans are increasing more quickly in areas where insurance market concentration is rising, controlling for other area characteristics such as the hospital market concentration.^[24]

Arguably the most relevant research in light of the recent proposed mergers are two studies of consummated mergers. Both found that structural changes in market concentration led to higher insurance premiums.

Other than the non-specific suggestion that operating efficiencies will result from the merger, Aetna and Humana have not provided persuasive evidence that the merger will reduce premiums, or even abate their rate of increase. For the third and fifth largest insurers nationwide, their combination is unlikely to yield further economy of scale. Further, with fewer competitors in the

²⁰ *Before the S. Comm. on the Judiciary, Subcomm. 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?*, 114th Cong. 11-12 (Sept. 22, 2015) (statement of Leemore S. Dafny, Ph.D, Professor of Strategy, Herman Smith Research Professor of Hospital and Health Services, Director of Health Enterprise Management, Kellogg School of Management, Northwestern University) [hereinafter, Dafny Senate Testimony] (original footnotes renumbered), available at <http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf>.

²¹ Steven Sheingold et al., ASPE Issue Brief, U.S. Dep't of Health and Human Services, *Competition and Choice in the Health Insurance Marketplaces, 2014-2015: Impact on Premiums* (July 27, 2015), available at <http://aspe.hhs.gov/basic-report/competition-and-choice-health-insurance-marketplaces-2014-2015-impact-premiums>.

²² Leemore Dafny et al., *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, 102 Am. Econ. Rev. 1161-1185 (Apr. 2012), available at <https://www.aeaweb.org/articles?id=10.1257/aer.102.2.1161>.

²³ Zirui Song et al., *Competitive Bidding in Medicare: Who Benefits From Competition?*, 18 Am. J. Managed Care 546-552 (Sept. 2012), available at <http://www.ajmc.com/journals/issue/2012/2012-9-vol18-n9/competitive-bidding-in-medicare-who-benefits-from-competition/P-3>.

²⁴ Erin E. Trish & Bradley J. Herring, *How do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums?*, 42 J. Health Econ. 104-114 (July 2015).

market and thus greater market power, the merged entity will be positioned to retain savings squeezed out of the combined operation, rather than returning these efficiencies to consumers in the form of lower premiums. As Dr. Dafny states, “when insurers merge, there’s almost always an increase in premiums.”²⁵

The medical loss ratio (MLR) requirements imposed by the Affordable Care Act (ACA) will not insulate consumers from unreasonable rate increases. A November, 2015 letter from the AMA to your Department summarized why the MLR is insufficient to protect consumers:²⁶

Also, as Professor Dafny has observed, for the regulations to constrain an exercise of market power “they must ‘bind:’ the statutory floors must be higher than we would otherwise see.” Thus, there may be substantial room for profitable merger-related price increases in the individual market in particular, notwithstanding the minimum MLR requirement. She further observes that because the MLR is calculated at the state and market level, it is conceivable that mergers can enable insurers to offset low MLRs in one geographic area or sub-segment with high MLR in another. In addition, the MLR does not address the level of the premium increase, only the percentage used for claims and quality activities. Finally, MLR regulation does not address non-price dimensions of health insurer competition such as product design, provider networks, and customer service. Therefore the MLR does not protect consumers from post-merger harm along “value” dimensions.

Proof for this proposition is provided by Aetna’s history of unreasonable rate increases, notwithstanding the MLR, as determined by the Department of Insurance and the California Department of Managed Health Care (DMHC). Consumers Union concisely summarized Aetna’s poor history at my April 27 hearing:

As the Commissioner knows, Aetna has a notably poor track record when it comes to rate setting in California. Among its CDI [*Department of Insurance*] regulated products, three small group products were deemed unreasonable over a four-year period. Within the DMHC products, four small group rate increases were deemed unreasonable and unjustified within only three years, with three of them occurring in 2015 alone. . . . They enacted all

²⁵ David Lazarus, *As Health Insurers Merge, Consumers’ Premiums are Likely to Rise*, L.A. Times, July 10, 2015, at C1 (quoting Erin Trish, researcher at USC’s Schaeffer School for Health Policy and Economics), available at <http://www.latimes.com/business/la-fi-lazarus-20150710-column.html>.

²⁶ Letter from James L. Madara, MD, Executive Vice President and CEO, American Medical Association, to William Baer, Assistant Attorney General, U.S. Department of Justice, Antitrust Division 12 (Nov. 11, 2015), available at <http://www.aha.org/content/15/151111-let-doj.pdf>.

seven unreasonable rate increases, affecting nearly a half-million Californians, at a cost of about 40 million dollars.²⁷

Aetna rate increase requests filed with the Department of Insurance which I found excessive and unreasonable have included:

- October 2015, 27.4% increase affecting 40,000 lives
- December 2014, 10.7% increase affecting 64,000 lives
- April 2012, 30.3% increase over 24 months for small employers with Aetna's PPO health insurance policies

A July 2015 DMHC press release cited four unreasonable rate increase requests to that Department in just over two years, including:

- July 2015, 21% increase affecting 13,000 lives
- May 2015, 19.2% increase affecting 16,000 lives
- December 2014, 17.3% increase affecting 9,500 lives
- March 2013, 11.4% increase affecting 20,000 lives

DMHC Director Shelley Rouillard stated: "Two thirds of [DMHC's] unreasonable premium rate findings have been for Aetna rate increases. Aetna's pattern of unreasonable increases equates to price gouging in today's market."²⁸

These excessive and unreasonable rate increases demonstrate that the MLR requirements have not and would not effectively restrain Aetna-Humana from imposing unreasonable increases on its customers when given enhanced market power.

2. Quality Will Decrease

The same anticompetitive factors that support higher premiums also act to reduce quality. As described by Professor Dafny, "[T]he competitive mechanisms linking diminished competition to higher prices operate similarly with respect to lower quality."²⁹ This is of particular concern in the context of the Aetna-Humana merger, as the acquiring party, Aetna, already has a poor quality record.

²⁷ Cal. Dep't of Ins., Public Hearing In Re: Investigative Hearing, Proposed Acquisition of Humana Inc. by Aetna Inc., 69:16-70:3, Apr. 27, 2016 [hereinafter Hearing Transcript], available at <http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/Condensed-Transcript-Aetna-Humana-hearing-April-27-2016.pdf>.

²⁸ Press Release, Cal. Dep't of Managed Health Care, DMHC Declares Premium Rate Increase by Aetna Unreasonable (July 16, 2015), <https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/2015/pr071615.pdf>.

²⁹ Dafny Senate Testimony, *supra* note 20, at 7.

Complaints to and examinations by my Department indicate ongoing quality and service issues by Aetna over the years:

- While the number of complaints from consumers and medical providers to the Department of Insurance decreased over 25% from 2014 to 2015 due to changes in Aetna's market position, the number of alleged violations identified by the Department increased by over 47% during that period.
- Over the past three years, the Department recorded alleged violations by Aetna involving 57 different legal requirements.
- Alleged violations by Aetna of one Insurance Code section governing proper claims handling increased by over 70% from 2014 to 2015, and by 474% from 2013 to 2015.³⁰
- Alleged violations of an Insurance Code section requiring specific notification of a consumer's right to request independent medical review increased 90% from 2014 to 2015.
- Alleged violations of an Insurance Code section requiring insurers to respond to a claim inquiry from the Department within 21 days increased by over 70% from 2014 to 2015.

These statistics document a continuation of problematic market conduct revealed in a Department examination of claims Aetna closed between June 2007 and March 2011. The exam found improper representation of pertinent facts and policy provisions to claimants, incorrect denials, unsatisfactory settlements, failure to inform insureds of the right to independent medical review, failure to conduct fair and thorough investigations of claims, and failure to provide clear reasons for denial of claims.

Additional evidence of Aetna's poor quality can be found in a targeted market conduct examination regarding Aetna's practices in the coverage of Applied Behavioral Analysis and speech therapy for the treatment of autism spectrum disorders. This examination cited 1,539 claims handling and denial violations.³¹

DMHC has had problems with Aetna similar to those encountered by my Department. DMHC's searchable database of enforcement actions lists over 100 such actions against Aetna Health of California, Inc. between 2001 and June 17, 2016, with over \$400,000 in fines. According to an analysis by the California advocacy group Health Access California, poor handling of patient

³⁰ Cal. Ins. Code § 10123.13 requires health claims to be paid, contested or denied within 30 working days; requires notices denying or contesting claims to provide information regarding the right to appeal the decision to the Department of Insurance; and requires the insurer to pay 10% interest on claims that are not paid within the required timeline.

³¹ Cal. Dep't of Insurance, *Website published report of the target market conduct examination of the claims practices of Aetna Life Insurance Company 4* (Jan. 16, 2013), <https://publishing.insurance.ca.gov/SitePages/FilteredSearch.aspx> (search "Company Name" for "Aetna"; then select exam report with "Post Date" of Jan. 16, 2013).

grievances accounts for most of DMHC's enforcement actions against Aetna, and a total of 46 fines since 2011.³² The database indicates fines of \$172,500 thus far in 2016 alone. In December 2014, DMHC fined Aetna \$200,000 for incorrect claim denials and other improper claim practices.³³

Market concentration results in poor quality because the lack of competition removes incentives to compete by improving quality. Also, the monopsony power inherent in a concentrated market constrains provider reimbursement below competitive levels, squeezing quality out of the system. Further, if a provider is threatened with exclusion from a network, the revenue loss the provider faces during the transition is irretrievably lost, without concomitant reduction in provider overhead.³⁴ This gives an insurer with oligopsony power substantial leverage over the provider. The AMA and the California Medical Association (CMA) summarized this in their statement to my Department concerning the Anthem-Cigna merger:³⁵

As Professor Dafny explained in her recent Senate testimony on this merger: "Monopsony 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 optimal."³⁶ She further explained that the "textbook monopsony scenario . . . pertains when there is a large buyer and fragmented suppliers."³⁷ 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.³⁸ The result is a reduction in compensation leading to diminished physician service and quality of care that harms consumers.³⁹

³² Letter from Anthony Wright, Executive Director, Health Access California, to Dave Jones, California Insurance Commissioner 6 (Mar. 2, 2016), available at http://www.health-access.org/images/pdfs/hac_comments_cdi-aetna-humana_merger_03022016.pdf.

³³ Cal. Dep't of Managed Health Care, Enforcement Matter No. 13-361, *Letter of Agreement, Aetna Health of California, Inc.* (Dec. 8, 2014), <http://wpsso.dmhc.ca.gov/enfactions/docs/2218/1420496881157.pdf>.

³⁴ Frech, III, *supra* note 16, at 7.

³⁵ *Statement of the American Medical Association and the California Medical Association to the California Department of Insurance RE: Anthem Application for the Proposed Acquisition of Cigna, March 29, 2016*, at 10-11 (original footnotes renumbered), available at <http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/AMA-CMA-statement-March-29-2016.pdf>.

³⁶ Dafny Senate Testimony, *supra* note 20, at 10.

³⁷ *Id.*

³⁸ Carol K. Kane, *Policy Research Perspectives: Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership* (Am. Med. Ass'n, July 2015).

³⁹ 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 (Oct. 20, 1999) (noting that

Further, the same anticompetitive forces noted above that will enable the combined entity to retain efficiency savings, rather than return them to consumers, will also enable the combined Aetna-Humana to retain the savings from its lower, oligopsony-level provider cost structure.

My Department has direct prior experience with the illusory nature of the claimed benefits of health insurer mergers. In 2005, UnitedHealthcare (UHC), the nation's largest insurer, acquired PacifiCare. However, UHC failed to honor its commitments to maintain quality service and expand its markets in California. Instead, services deteriorated significantly for both policyholders and providers. As here, UHC attempted to justify its acquisition of PacifiCare by touting increased efficiencies and cost savings. Indeed UHC was able to exceed its three-year cost-cutting goal of \$350 million dollars 18 months after the merger, but at a significant negative impact on quality of service. I ultimately found a pattern of unfair claims practices, totaling 908,547 violations, as the quality of its services decayed.⁴⁰

Aetna-Humana's combined size in many MA markets around the country, and thus its increased bargaining power relative to providers post-merger, may prompt it to reduce provider reimbursement rates to below-competitive points at which quality will inevitably be sacrificed. A larger Aetna may also have less incentive to properly handle provider reimbursements, as occurred with UHC.

As separate entities, Aetna and Humana can compete between themselves and with other insurers for members based on premiums and quality of care. If the merger proceeds, these competition benefits will be lost.

III. THE AETNA-HUMANA MERGER WILL SIGNIFICANTLY REDUCE COMPETITION

A. *The California Commercial Insurance Market is Highly Concentrated, Even before Recently Proposed Mergers*

Even before the proposed mergers currently under review (Aetna-Humana, Anthem-Cigna), the California commercial market was characterized by high levels of concentration. For example, in the employer-sponsored and individual markets, 40 of California's 58 counties are "highly concentrated," as defined by having HHI values over 2,500. Similarly, all 18 of the remaining counties are "moderately concentrated," with HHI values between 1,500 and 2,500.⁴¹

anticompetitive effects can occur even if conduct does not adversely affect ultimate consumers who purchase end-product), available at <https://www.justice.gov/atr/speech/buyer-power-concerns-and-aetna-prudential-merger>.

⁴⁰ *In the Matter of the Order to Show Cause and Accusation Against PacifiCare Life and Health Insurance Company*, Case No. UPA 2007-00004 (Cal. Dep't of Ins. June 9, 2014) (Commissioner's Decision and Order), at 6 & 215 (discussion of cost-cutting goal, and summary table of violations), <http://www.insurance.ca.gov/0250-insurers/0500-legal-info/0600-decision-ruling/0100-precedential/upload/219450.pdf>.

⁴¹ *Testimony Regarding Anthem's Proposed Acquisition of Cigna Corporation by Brent D. Fulton, Richard M. Scheffler, and Daniel R. Arnold at the California Dep't of Insurance, March 29, 2016*, at 25 tbl.A1 (county HHI data), available at <http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/CDI-Testimony-re>

The degree of concentration within the California health insurance market is shown in even starker relief when various segments of the market are considered in detail. For example, in 2015, for coverage through the California Health Benefit Exchange (“Covered California”) in Region 1 (the northern tier of 22 counties⁴²), 97.7% of the coverage was provided by one company, Anthem.⁴³ As a further example, in Region 3 (Sacramento and nearby Sierra counties), three large companies control 97.8% of the Exchange individual market.

Given the high degree of concentration in the California market, and the challenges posed by the state’s size, geographic size and variation, and by the nation’s largest population of potential insureds, it is exceptionally difficult for new insurers to enter, let alone compete in the California market with any degree of success.

B. High Barriers to Entry Mandate Preservation of Competitors with the Potential to Enter New Markets

As your Department recognizes, and others have noted in letters to you regarding this merger in particular, it is difficult for new health insurers to enter a market, particularly one as large as California. As DOJ and FTC (the Agencies) have explained: “Entry barriers... include: state laws and regulations, economies of scale, and firm reputation.”⁴⁴ More recently, the DOJ Antitrust Division, after studying barriers to entry into health insurance markets, concluded that significant barriers exist, including the ability of new entrants to obtain the same level of discounts from providers as larger, more established firms and the reluctance of agents to recommend or sell the products of companies that lack brand-name recognition in the market.⁴⁵ Added to that is the difficulty new entrants have in contracting with the number of quality providers necessary for an attractive network.

Under the Merger Guidelines, the Agencies consider the extent to which entry of new competitors will be “timely, likely and sufficient” when evaluating the competitive effect of a merger.⁴⁶ On a national basis, the Aetna-Humana merger has direct anticompetitive effects. The large Aetna-Humana post-merger market shares in various regional markets and product lines, especially in numerous MA markets, and the HHIs above 2,500 and HHI increases exceeding

[Anthem-and-Cigna-Fulton-Scheffler-and-Arnold-032916-final.pdf](#); see *Horizontal Merger Guidelines*, *supra* note 4, at 19.

⁴² The 22 counties in Region 1 are listed in Cal. Ins. Code § 10965.9(a)(2)(A)(i).

⁴³ Covered California, *Health Insurance Companies and Plan Rates for 2016* at 35 (Oct. 29, 2015), available at <https://www.coveredca.com/PDFs/7-27-CoveredCA-2016PlanRates-prelim.pdf>.

⁴⁴ Fed. Trade Comm’n & U.S. Dep’t of Justice, *Improving Health Care: A Dose of Competition*, ch. 6, at 8 (July 2004), available at <https://www.justice.gov/atr/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice#toc>.

⁴⁵ See Sharis A. Pozen, Acting Asst. Att’y Gen., U.S. Dep’t of Justice, Antitrust Division, Competition and Health Care: A Prescription for High-Quality, Affordable Care, Prepared Remarks Before the World Annual Leadership Summit on Mergers and Acquisitions in Health Care (Mar. 19, 2012), available at <https://www.justice.gov/atr/file/518931/download>.

⁴⁶ *Horizontal Merger Guidelines*, *supra* note 4, §§ 9-9.3, at 27-29.

200 points in many of those markets, make new entry even more difficult. It is simply impossible to believe that a new entrant, within a two to three year period, would decrease the Aetna-Humana market share and HHI statistics in even a few, let alone most or all of the states, MSAs or counties identified in the AMA, Commonwealth Fund, KFF and AHA studies, to the point that the merger would not be rebuttably presumed unlawful under the Merger Guidelines standards and current case law.

In addition to the direct anticompetitive effects of the Aetna-Humana merger, an even more significant effect of the merger is its removal of an important and strong potential competitor, Humana, from the insurance market in California and the nation. New entrants to commercial insurance markets face a daunting prospect, as barriers to entry are high. As a consequence, the loss of an insurer, such as Humana, that has an existing footprint in a coverage segment in California (such as, in Humana's case, in MA) removes a competitor with the credible capability to expand into the commercial market. An existing competitor in one segment of the market can use supply-side substitution (through, for example, leveraging its existing provider relationships) to enter a new segment of the market.⁴⁷ Loss of such a potential competitor exacerbates the trend towards concentration in the commercial marketplace, with all of the ensuing consumer detriments, described above, that such concentration brings.

In California, experience has shown that only companies with existing relationships with health providers and facilities have a realistic likelihood of successful entry into the commercial health insurance market. The Merger Guidelines recognize that likelihood of successful market entry by new competitors is a key element in the analysis of proposed mergers. I recommend that your Department apply that element in considering the impact of removing Humana as a potential new competitor in various geographic or product markets in which it currently has relatively little presence.

The Merger Guidelines recognize three factors involved in market entry: timeliness, likelihood, and sufficiency.⁴⁸ For each of these factors, new entrants in the health insurance market in California and in markets outside of California face considerable obstacles. The first factor considered in an evaluation of market entry, timeliness, considers whether a new entrant into a market can enter with sufficient speed to offset anticompetitive forces within the market. It is difficult, however, for a new entrant into the California commercial market, and markets outside of California, to contract with sufficient providers to enable it to quickly enter and compete. This inherent delay in timely entry, however, is moderate where, as would be the case with Humana, the potential new entrant already has pre-existing provider relationships and provider networks in the same geography because of its presence in a different market segment (MA) in that geographic region.

The second of the three factors in an evaluation of market entry, "likelihood," considers the profitability of fresh entry into the market, i.e. whether:

⁴⁷ See also Frech, III, *supra* note 16, at 24.

⁴⁸ *Horizontal Merger Guidelines*, *supra* note 4, §§ 9.1-9.3, at 27-29.

the assets, capabilities, and capital needed, and the risks involved, including the need for the entrant to incur costs that would not be recovered if the entrant later exits.⁴⁹

Profitability for new entrants into the health insurance market has, however, proved elusive. Insurers participating in the expanded markets made possible by the ACA encountered a risk pool that had greater care costs than anticipated, adversely affecting profitability. Also, the inability of the federal government to fully fund the Risk Corridor program has crippled the ability of many new market entrants to achieve profitability.

Particularly instructive with regard to the inability of new market entrants to succeed is the recent experience with CO-OPs. The ACA created a new type of insurer, a Consumer Operated and Oriented Plan (CO-OP). These CO-OPs faced:

the barriers to entry that all newcomers confront in highly concentrated health insurance markets. Among other challenges, they must demonstrate adequate capitalization and effective governance to gain a state license, build or acquire a network of providers at a reasonable cost, price plans competitively without any historical claims data, and build brand recognition and trust. In addition, many new market entrants must, at least initially, outsource critical functions such as customer support and claims processing, which adds to overhead costs and reduces their ability to manage quality.⁵⁰

Notwithstanding substantial federal loans to cover their initial start-up phase, however, the vast majority of the CO-OPs nationwide have failed, or are severely struggling financially. The demise of the CO-OPs demonstrates the difficulty inherent in developing a new market entrant in health insurance that has no previous experience, reputation, or lacks the financial strength of a national insurer. This shows the importance of maintaining the availability of experienced potential competitors, such as Humana, which can feasibly enter and compete in the commercial market.

The third, and final, element of the market entry analysis described in the Merger Guidelines is “sufficiency,” which includes an evaluation of:

Constraints that limit entrants’ competitive effectiveness, such as limitations on the capabilities of the firms best placed to enter or reputational barriers to rapid expansion by new entrants.⁵¹

⁴⁹ *Id.* § 9.2, at 29.

⁵⁰ Sabrina Corlette et al., *The Affordable Care Act CO-OP Program: Facing Both Barriers and Opportunities for More Competitive Health Insurance Markets*, The Commonwealth Fund Blog (Mar. 13, 2015), <http://www.commonwealthfund.org/publications/blog/2015/mar/aca-co-op-program>.

⁵¹ *Horizontal Merger Guidelines*, *supra* note 4, at 29.

As described above, there are substantial barriers to new health insurers entering markets: there is substantial lead time and expense involved in developing provider networks, and reputational barriers to establishing contracting relationships with a myriad of providers, employers, and consumers who are used to dealing with an insurer with long-standing market dominance, which by their bulk displace all potential small competitors. In addition to the difficulty inherent in establishing new provider relationships, new entrants are faced with resistance from insurance agents. As your office has previously noted, “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.”⁵²

Newly formed or existing private insurers have fared no better than CO-OPs with regard to market entry. Moda Health Plan, Inc., a well-established, highly regarded and then prosperous Oregon-domiciled carrier recently entered into a new market, ACA coverage. It promptly lost \$31 million in the first nine months of 2015, more than half of its excess capital and surplus.⁵³ Moda found it difficult to enter a new health market and make a profit due to the high cost of entry and the adverse selection that new entrants encounter. Moda’s experience not only shows the difficulty of entering into a new product line or distribution channel, it signals to other carriers considering entry that they should think twice about entering. Similarly, SeeChange Insurance Company, a California-based health insurer, sustained significant losses because it could not compete effectively with entrenched, large health insurers, and I ultimately had to place the company into liquidation. It was unable to establish effective provider networks and attract a reasonably healthy book of business in competition with established market participants.

Unlike Moda and SeeChange, however, Humana has a prior history of effective operation within the California commercial insurance market and in markets outside of California. Humana offered individual health insurance in the individual market in California as recently as 2014, and in the small group market as recently as 2015; and so has a history of having competed with Aetna and other health insurers in the commercial markets. Nationally, in 2016 Humana offered individual health insurance products through Exchanges in 15 states, and outside the Exchanges in 21 states. Further, Humana is an active competitor in Medicare Advantage markets in California and in markets outside of California, and thus already has established provider relationships and contracted with providers to form provider networks. Humana thus has the demonstrated capacity to compete in the California commercial markets and in markets outside of California, but California and the nation will lose access to this capacity if Humana is absorbed into Aetna.

As the nation’s largest health insurance market, containing four highly populated MSAs and large and disparate rural areas, the California health insurance marketplace is differentiated by region, product type, and market segment. As difficult as it may be to break into the health

⁵² Pozen, *supra* note 45, at 7.

⁵³ *In the Matter of Moda Health Plan, Inc.*, Case No. INS 16-13-001 (Or. Dep’t of Consumer & Bus. Servs., Div. of Fin. Reg., Jan. 27, 2016) (Order of Immediate Supervision), http://www.cbs.state.or.us/external/ins/admin_actions/actions_2016/insurer_2016/financial_2016/other_2016/16-13-001.pdf.

insurance business against a large, established competitor in a smaller, relatively homogenous state, it is even more difficult, if not impossible, for a new entrant to gain “timely” and “sufficient” market share in California. Examples of the barriers presented by California’s geographic and demographic diversity include the following: The demographics of consumers in rural northern California differ from those of rural southeastern California, and the demographics of rural Californians differ from those of urban Californians, requiring multiple sales and marketing approaches (in a multitude of languages); competitors vary by region, and thus require new entrants to use a variety of sales and marketing methods to effectively compete. Furthermore, provider groups and hospital chains present different contract challenges in different regions. These factors present substantial impediments to a new or smaller insurer (or, in fact, any insurer) entering each new geographic and product market relative to a larger, established competitor. Cumulatively, these challenges increase a new entrant’s costs as it attempts to gain market share, which may make its new regions or products unprofitable for years. The challenges delay the time it takes to gain market share. The challenges may make it impossible to ever gain “sufficient” market share to mitigate the effects of a merger even if the new entrant has the capital to absorb the short-term losses from new entry costs.

In a market as large and concentrated as California’s, only an established competitor, such as Humana, has the power and presence to push its way into new markets. The same is true in markets across the United States. Permitting this merger precludes this possibility.

C. Aetna and Humana Have Provided No Reliable Evidence Indicating that the Asserted Efficiencies Would Counteract the Harm to Competition or Disproving the Likely Harms from the Merger

1. The Companies Have Not Provided Reliable Evidence of Claimed Efficiencies, Nor Provided Reliable Evidence that Efficiency Savings Will Be Passed on to Consumers

The Merger Guidelines note that even when a merger increases concentration, it can nevertheless “generate significant efficiencies and thus enhance the merged firm’s ability and incentive to compete,” which may benefit consumers. However, “[e]fficiency claims will not be considered if they are vague, speculative, or otherwise cannot be verified by reasonable means” or if the efficiencies could be achieved unilaterally or by collaborative means short of a merger.

The Agencies typically obtain substantial information about a merger from the parties themselves. When the parties fail to present persuasive evidence about a merger’s benefits, such as actual efficiencies, one can infer that evidence is lacking.

In filings with DMHC, Aetna asserted that the proposed acquisition would result in \$1.05 billion dollars of savings from reduced selling, general, and administrative expenses. At my April 27, 2016 hearing, when I asked Aetna’s Executive Vice President and Head of Government Services, Francis Soistman, to detail the magnitude of these anticipated savings, and what

percentage of these savings would be passed on to consumers, he was unable to provide an estimate.⁵⁴

MR. SOISTMAN: Well, the savings will come from multiple areas. Initially it would come from the redundancy of the administrative servers incorporated overhead. The fact that we have had two public companies, obviously we won't need to have two public companies going forward.

In the longer term, remember that we'll have a ramp-up period. It will be the ability to combine information technology and operating systems to be able to retire systems. And that will produce the larger savings over time. It will take time. That's -- that obviously is the most complex part of that. Because that's where you have to be very mindful of making sure that our members don't experience any disruption.

COMMISSIONER JONES: The October 8th, 2015 filing by Aetna with the Department of Managed Health Care, in that filing, Aetna noted that approximately 1.05 billion dollars of savings would come from reduced selling, general and administrative expenses. Can you elaborate in a little more detail where specifically that 1.05 billion will come from in the category of selling, general and administrative expense reductions?

MR. SOISTMAN: Well, that's how we put in a broader category, the examination I provided are those that I would still refer to. It's the first view of opportunity wherever there's unnecessary redundancy. And the fact that we can take the best of both organizations and determine which of those should be, you know, the surviving best practice, best operating system and so forth, and eliminate the other. And that will occur over time. There will be other forms of saving, as you know, as we are able to improve our rebate arrangements with pharmacies for example, our network arrangements, where Humana may not have access to a provider network that Aetna has. And this will now enjoy access to that, for their commercial business. Aetna may enjoy Humana's network in overlapping markets over time. So that will produce savings as well. So there will be multiple savings over time.

COMMISSIONER JONES: The filing indicated 100 million dollars reduced network expenses. I'm wondering if you can share

⁵⁴ Hearing Transcript, *supra* note 27, 38:14-41:10, 43:8-44:2.

with us how the combined entity anticipates obtaining 100 million dollars in shared network expense savings.

MR. SOISTMAN: I don't have that detail with me today, Commissioner.

COMMISSIONER JONES: Could you provide that to us separately?

MR. SOISTMAN: I'm sure we can provide additional detail.

COMMISSIONER JONES: Appreciate it. And then the filing also indicated 100 million dollars in reduced medical management expense, and I'm wondering if you could share with us how 100 million dollars in reduced medical management expense will be obtained.

MR. SOISTMAN: It really goes back to that redundancy, where we're going to take best practices. So both organizations today have different care management systems that support our ability to do effective, complex case management, utilization management and so forth. And we will be able to take the best, and utilize that across all of the businesses and combined businesses over time, and therefore eliminate older, perhaps less effective systems.

COMMISSIONER JONES: If you have additional detail, we would welcome that as well.

MR. SOISTMAN: I'll see what we can provide.

....

COMMISSIONER JONES: Does the company have any estimate with regard to the portion of the 1.25 billion dollars in savings, that it will reduce premiums or reduce the rate of premium growth for policyholders?

MR. SOISTMAN: We have not prepared those estimates to date.

COMMISSIONER JONES: Is there any enforceable guarantee contained within the merger or any of the approvals that you're seeking or have obtained from any regulatory authority that would guarantee that some portion of the 1.25 billion dollars in savings would result in lower premiums for policyholders?

MR. SOISTMAN: Well, what we have stated, at various times, our chairman and CEO testified before Congress and made a

commitment that we would be returning a significant part of the savings to our consumers. But we have not quantified that to a precise number. And again, we would do that in multiple forms. It would be through investments in the technology and the programs, as well as ways to mitigate the rising cost of health care.

However, supplemental responses provided by the companies after the hearing did not provide sufficient detail or specificity to be persuasive; the anticipated savings appear to be speculative.

As then Assistant Attorney General William Baer told the United States Senate Judiciary Subcommittee on Antitrust, Competition Policy, and Consumer Rights in March, “in evaluating the legality of mergers under the antitrust laws, the antitrust agencies consider the extent to which claims of merger-specific cost savings will be passed on to consumers.”⁵⁵ In the Aetna-Humana merger, the testimony and documents in the public record do not support a conclusion that Aetna will pass meaningful savings resulting from the merger on to consumers, if those savings even materialize.

The testimony of Professor Dafny and others that health insurer mergers result in price increases, not price decreases, thus remains effectively unrebutted by the parties. Simple economic theory predicts that if the transaction increases the parties’ market power, nothing will force them to pass savings through to consumers.

2. Neither Aetna nor Humana Have Provided Reliable Evidence that Quality Will Improve

At the hearing before my department, Aetna and Humana’s representatives spoke only in generalities about quality improvement. As mentioned above, critics of health insurer mergers contend that quality usually decreases when there are so few insurers that they lack an incentive to compete to attract or retain customers by improving quality, and from oligopsony power in relation to physicians. That there is an economic basis for post-merger decreases in quality was mentioned in letters to DOJ regarding the Aetna-Humana merger by the AMA and others.⁵⁶

D. Allowing the Merger Prevents Each Insurer from Challenging the Other in Markets where One Insurer’s Market Share Is Large and the Other’s Is Small

The Aetna-Humana merger would reduce existing competition, result in enhanced market power for the merged entities, and thereby bring about higher prices, lower quality of care and other harms. However, another compelling reason to block the merger is to allow future competition between the two companies (and with other large carriers) in markets where one company currently has a large market share but the other company does not.

⁵⁵ Responses of Ass’t Att’y Gen. Bill Baer to Questions Submitted for the Record, S. Judiciary Comm. on Antitrust, Competition Policy, and Consumer Rights Hearing: “Oversight of the Enforcement of the Antitrust Laws,” March 9, 2016, at 6, Q.1 from Sen. Franken, <https://www.judiciary.senate.gov/imo/media/doc/Baer%20Responses%20to%20QFRs.pdf>.

⁵⁶ See, e.g., Letter from James. L. Madara, Exec. VP & CEO, American Medical Association, *supra* note 26.

According to the companies, Aetna is the country's third largest insurer, with 23 million lives covered by medical plans, and 2015 revenue of \$60 billion.⁵⁷ Humana is the country's fifth largest insurer, with nearly 10 million lives and 2015 revenue of \$54 billion.⁵⁸ Thus, in every market where one of the two companies has a minimal presence and the other has a substantial presence, the company with a negligible presence will nonetheless have the expertise and resources to overcome the barriers to entry that confront smaller companies and, over several years, become a challenger to the existing dominant carriers (including its prospective partner in this merger). Indeed, given the imperative for companies to grow or die, absent this merger it should only be a matter of time until each company expands into markets where its presence is currently minimal and the other's (or some other dominant player's) is significant. Approval of an Aetna-Humana merger would eliminate both companies as potential future competitors to each other and as separate competitors to UnitedHealthCare, Anthem, and other large national and regional insurers.

E. Divestitures will not fully restore competition or adequately protect Californians

Divestiture of some portions of either or both companies or undertakings as to rates, quality, or investments will not remedy or mitigate the anticompetitive impacts and results of this merger. The law requires that any remedies fully restore competition. The necessary divestitures in the MA markets would be close to impossible to accomplish given the number and scale of the impacted areas, and would also defeat the companies' primary intention of combining their MA plans. Additionally, divestiture to a company with an already significant market share would not remedy the competitive situation, and divestiture to a new entrant would likely fail in short order. A retrospective analysis of mergers indicates that even smaller divestitures fail to achieve the desired pro-competitive goals.⁵⁹ Further, as you know, divestitures in health insurance mergers challenged by the Division in the past have failed.

IV. DMHC APPROVAL: REVIEW LIMITED TO KNOX KEENE ACT AND UNDERTAKINGS DO NOT ELIMINATE ANTI-COMPETITIVE IMPACTS OF MERGER

On June 20, 2016, the California Department of Managed Health Care gave its approval of the Aetna-Humana merger, inasmuch as it applied to the health care service plans under its jurisdiction.⁶⁰ (Humana does not have an insurance subsidiary that is domiciled or commercially

⁵⁷ Aetna & Humana, *Fast Facts*, <http://www.aetnaandhumana.com/why-were-combining/fast-facts/>; Aetna, *Aetna Facts*, <https://www.aetna.com/about-us/aetna-facts-and-subsidiaries/aetna-facts.html>.

⁵⁸ NASDAQ, Inc., Humana Inc. Revenue & Earnings Per Share (EPS), <http://www.nasdaq.com/symbol/hum/revenue-eps>.

⁵⁹ John Kwoka, *Merger Control, and Remedies: A Retrospective Analysis of U.S. Policy* (MIT Press 2015).

⁶⁰ Press Release, Cal. Dep't of Managed Health Care, DMHC Approves Aetna's Acquisition of Humana (June 20, 2016), <http://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/pr062016.pdf>; DMHC, *Undertakings: Aetna Inc. & Humana, Inc.* (June 17, 2016), available at <http://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/u061716.pdf>.

domiciled in California. Thus, under the Insurance Holding Company System Regulatory Act,⁶¹ the Department of Insurance does not have approval authority for this proposed merger.) The DMHC review was conducted under the Knox-Keene Act, the act under which health care service plans are regulated in California.⁶²

The Director of DMHC, Shelley Rouillard, described DMHC's review in a California State Senate hearing on health care market consolidations:

Senator Hernandez: Question, both to Department of Managed Health Care and Department of Insurance. I know each one of you regulate the various insurance markets that are within your purview. And I think the Department of Managed Health Care talked about what they do for mergers as well as Department of Insurance. When you do that, and I know that Department of Insurance has hearings, and I wasn't sure if I heard if you have a hearing as well. But do you do that mindful of what the impact of cost is to the consumer? Is that one of the overriding thought processes for both of you?

Director Rouillard: So, we're limited by what's in the Knox-Keene Act as to what we can review in terms of, you know, some of the organizational changes and things that I mentioned. . . .

Senator Hernandez: Is that because of resources and what your limit of scope with regard to how you're working within the Knox Keene framework, is that what's limiting you?

Director Rouillard: Yes.⁶³

While DMHC's approval of the Aetna-Humana included undertakings related to rates and quality, the nature of the review was, as Director Rouillard stated, limited by the scope of the Knox-Keene Act. A bill was introduced in the California Legislature this session, Senate Bill 932 (Senator Hernandez) to provide DMHC with broader scope regarding the review of competition issues in mergers under its jurisdiction.⁶⁴ As noted in the April 20, 2016 Senate Committee on Health bill analysis for Senate Bill 932:

This bill gives explicit authority to DMHC to review and approve mergers and acquisitions of health plans and other entities and

⁶¹ Cal. Ins. Code §§ 1215-1215.18.

⁶² The Knox Keene Health Care Service Plan Act of 1975, Cal. Health & Safety Code §§ 1340-1399.864.

⁶³ *Cal. State S. Health Comm. Informational Hearing on Health Care Market Consolidations: Impacts on Cost, Quality, and Access, March 16, 2016*, video of proceedings at 2:15:27-2:17:04.

⁶⁴ S.B. 932, 2015-2016 Reg. Sess. (Cal. 2016), available at http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB932.

requires consultation with the AG. As part of the review process the DMHC is required to analyze impacts of the transaction on market competition. CDI has authority to review domestic insurance companies under the department's jurisdiction for impacts on market competition. However, the limit on this authority is to companies that are domestic insurers that are organized in California.

The DMHC review was conducted under the Knox-Keene Act. However, as the insurance regulator of the largest insurance market in the United States, I believe it is critically important to thoroughly analyze all potential impacts of this merger on competition and consumers in the health insurance markets in California and in markets outside of California, based on the Merger Guidelines of the United States Department of Justice and FTC and general principles of anti-trust law. The DMHC undertakings do not eliminate the anticompetitive impacts of the Aetna-Humana merger. I have identified substantial competitive issues, both nationally and within California, which I urge the U.S. Department of Justice to consider. In particular, the competitive impact of removing an otherwise viable competitor is of particular concern.

V. CONCLUSION

Based on the Merger Guidelines and data from the AMA, Commonwealth Fund, Kaiser Family Foundation and AHA, the proposed merger of Aetna and Humana will substantially lessen competition in the Medicare Advantage markets in hundreds of counties in ten or more states, affecting millions of seniors throughout the country. Applying the analysis typically used by the Agencies, the merger will substantially enhance market concentration and market power in these markets. A merger of this size and type, according to authorities on health insurer mergers, will likely lead to increased prices and decreased quality.

Further, partial divestiture or other remedies traditionally used by the Department of Justice will not adequately protect consumers or address the adverse consequences of a merger of Aetna and Humana. Traditional methods to avoid market concentration will not address poor service qualities, the power to charge excessive rates or the loss of a potential market participant that has the resources to enter into new markets.

Finally, and most significantly, the Aetna-Humana merger will eliminate Humana as an important potential competitor in the commercial market. In the present environment in health insurance, it is impossible to create *de novo* a competitor with the strength, experience, and provider relationships that Humana has established. Loss of Humana will be the loss of an irreplaceable competitive resource.

For these reasons, I am opposed to the merger of Aetna and Humana. The Aetna and Humana merger will harm Californians, especially seniors, and our health insurance market. The Aetna and Humana merger will harm consumers in markets across the United States. Accordingly, I urge the United State Department of Justice to block the Aetna-Humana merger.

Sincerely,



DAVE JONES
California Insurance Commissioner

cc: Mark Bertolini, Chairman and CEO Aetna
Bruce Broussard, President and CEO Humana, Inc.