California Medical Association
Physicians dedicated to the health of Californians
1201 J Street, Suite 200, Sacramento, CA 95814-2906 • 916.444.5532 • Fax 916.444.5689

April 29, 2016

Dave Jones, Commissioner
California Department of Insurance
300 Capitol Mall, Suite 1700
Sacramento, CA 95814

Comments submitted via e-mail to: mergercomments@insurance.ca.gov

Dear Commissioner Jones:

The California Medical Association (CMA) writes to express our concerns regarding Aetna's proposed acquisition of Humana. CMA is a not-for-profit, professional association for California physicians with more than 42,000 members. CMA physician members practice medicine in all specialties and modes of practice throughout California. For more than 150 years, CMA has promoted the science and art of medicine, the care and well-being of patients, the protection of the public health, and the betterment of the medical profession. CMA and its physician members are committed to the protection of the physicians' ability to exercise their medical judgment to provide quality and effective care for their patients.

CMA has long been concerned with the consolidation of health plans and health insurers and the reduction of competition. Physicians across the country have serious concerns with the recent, rapid wave of proposed mergers and consolidation of health plans and health insurers.[1] Physicians are concerned with the proposed mergers' impact on patients in terms of health care access, quality, and affordability.

Allowing Aetna to acquire Humana would lessen competition in California to the detriment of physicians and their patients. The success of health care reform will depend as much upon its regulatory implementation as it will upon healthy, competitive health plan markets. In order to improve health care we must encourage competitive health insurance markets that provide ample choice, high quality, and transparency. CMA urges the California Department of Insurance (CDI) to carefully review Aetna's proposed acquisition of Humana.

Below we outline specific reasons for CMA's concern regarding Aetna's proposed acquisition of Humana.

Aetna-Human Merger Raises Competitive Concerns

On September 9, 2015, Cattaneo & Stroud, Inc., a healthcare consulting group, presented to the Department of Managed Health Care's (DMHC) Financial Standard Solvency Board (FSSB) their

[1] Hereinafter the terms health plan and health insurer are used interchangeably in the context of discussing the merger and consolidation of companies that provide health insurance and health plan products.

report, "Effect of Proposed California HMO Acquisitions." The report found that an Aetna-Humana merger would lessen competition in eight California counties. Those counties were:

Aetna-Humana Merger

California Counties Where Competition Lessened in Medicare Advantage Market

Rank	County	Population
1	Los Angeles County	10,170,292
2	San Diego County	3,299,521
3	Orange County	3,169,776
4	Riverside County	2,361,026
5	San Bernardino County	2,128,133
10	Fresno County	974,861
11	Kern County	882,176
13	Ventura County	850,536

Of the eight counties, five of those counties include California's most populous counties, Los Angeles, San Diego, Orange, Riverside and San Bernardino.

The loss of competition resulting from an Aetna-Humana merger would likely be permanent and the acquired health insurer market power would be durable.[2] Increasing Aetna's market power would further incentivize it to restrict access to care, dictate physician's clinical judgment, and severely restrict

[2] See, e.g., Letter from James L. Madara, M.D., Exec. Vice President, American Medical Association, to William Baer, Assistant Attorney General, U.S. Dept. of Justice Antitrust Division (November 11, 2015)(on file with the California Medical Association).

physician resources, resulting in a significant degradation of their ability to provide the quality of care that patients value and need.[3]

Physicians Overwhelmingly Oppose Aetna's Proposed Acquisition of Humana

CMA, in collaboration with the AMA, conducted a survey of California physicians to gauge their perspective on the Aetna-Humana merger, and to gather data on how physicians currently negotiate with insurance companies. This survey was administered to members of CMA. In a brief period of time, CMA received one of the highest response rates for such a survey with 989 physician practices responding to the survey.

The survey results demonstrate that physicians overwhelmingly oppose the mergers. They believe that the mergers would give insurers more influence over physicians' clinical and business practices and would force physicians to cut costs, resulting in a significant degradation of their ability to provide the care patients value and need. Physicians do not believe that the mergers are necessary to gain efficiencies—as insurers claim—in areas such as innovative payment programs and care management strategies that will benefit patients. The survey results also demonstrate that:

- Eighty-three percent (83%) of physicians strongly or somewhat oppose the merger of Aetna and Humana;
- Seventy-six percent (76%) of physicians believe the Aetna-Humana merger would make the contracting negotiation process less favorable;
- Seventy-eight percent (78%) of physicians believe the Aetna-Humana merger is very or somewhat likely to lead to narrower physician networks, which will reduce access to patient care;
- More than 75 percent (75%) of physicians believe they will be pressured not to engage in aggressive patient advocacy if the merger is approved;
- Almost 90 percent (90%) of physicians believe that it is either very likely or somewhat likely that reimbursement rates will decrease and the result will be a reduction in the quality and quantity of services physician can provide to their patients;
- Eighty-three percent (83%) of physicians report they disagreed or strongly disagreed that the merger is necessary to gain efficiencies;

[3] California Medical Association Survey, *The Anthem-CIGNA and Aetna-Humana mergers: Putting profits ahead of patients*, (on file with the California Medical Association).

- Eighty-four percent (84%) of physicians believe that if the mergers are approved, insurers will have even more influence over physician practices and physicians will be forced to cut costs, which will result in a significant degradation of their ability to provide the care that patient's value and need; and

- Physicians report if the merger is approved and the physician does not continue to have a contract with the merged plan(s) they would be forced to cut staff and salaries, reduce investment in practice infrastructure, spend less time with patients, cut quality initiatives, close their practice and/or retire.

Reduction in Health Care Access

Insurers are already creating very narrow and restricted networks that force patients to go out-of-network in order to access care. The Aetna-Humana merger, if approved, would further reduce economic pressure on the combined company to offer broader networks as a means to compete for enrollees and subscribers. CMA is convinced that an Aetna-Humana merger would result in less competitive pressure on all insurers to respond to patients' access needs. Indeed, the federal DOJ has found in earlier merger cases that, where the merged company is presumed to enhance its market power, the result is usually a reduced availability of physician services.[4]

While limited or tiered networks are currently being used by health plans to control health care costs, when a health plan increases its market power through a merger, CMA is concerned that the merged company will be further incentivized, and less hindered by competition, to utilize restricted networks to limit patient access to medically necessary care and increase profits. CMA also believes that patients' access to health care will be greatly hindered by a reduction in administrative capacity and resources post merger as the combined company seeks to cut costs and consolidate resources. The aftermath of past health insurer mergers has taught California physicians and their patients that post merger, the consolidated entity usually lacks the administrative capacity and resources to administer quality health care access to patients. California physicians, for example, experienced this with the United/PacifiCare merger, where post merger the company did not have enough dedicated resources in California to administer claims, authorizations, or otherwise facilitate timely access to health care.[5]

---

[4] See, e.g., Letter from James L. Madara, M.D., Exec. Vice President, American Medical Association, to William Baer, Assistant Attorney General, U.S. Dept. of Justice Antitrust Division (November 11, 2015)(on file with the California Medical Association).

[5] The California Department of Insurance imposed penalties against United Healthcare of more than $173 million dollars for 900,000 violations of the insurance code from 2005 to 2008. The administrative proceeding arose from problems that surfaced after United Healthcare's acquisition of PacifiCare in 2005, which had been heavily scrutinized by regulators. Shortly after the transaction, the CMA saw a spike in complaints from physicians about the way PacifiCare was processing claims and contracts. CMA forwarded dozens of physician complaints to the DOI and requested the insurance regulator investigate. After conducting its own market conduct investigation, the DOI filed an administrative proceeding against United Healthcare, charging PacifiCare with violations that included: (1) failing to give providers notice of their appeal rights and members notice of their right to an independent medical review; (2) failing to timely pay or correctly pay claims as well as interest on late-paid claims; (3) failing to acknowledge receipt of claims; (4) failing to timely respond to provider disputes; (5) illegally closing claims files; and (6) sending untimely collection notices for overpayment.

Reduction in Health Care Quality

An Aetna-Humana merger can be expected to lead to a reduction in health care quality. The federal DOJ department has found that health insurer monopsony, or buyer power, acquired through a merger will likely degrade healthcare quality.[6] Patients fare better when there is a competitive market place for purchasing physician services. Larger mergers, such as the proposed Aetna-Humana merger, which result in an increase in a plan's monopsony power and physicians receiving reimbursement rates below competitive market levels. As a result, patients may be harmed in a variety of ways. Physicians may be forced to spend less time with their patients in order to meet their practice expenses. Physicians may also be hindered in the ability to invest in new equipment, technology, training, staff and other practice infrastructures that could improve the access and quality of patient care. In addition, a plan's increase in monopsony power could limit a physician's successful transition into new value-based payment and delivery models. History also has shown that larger mergers, such as the proposed merger betweenAetna-Humana , typically result in lower reimbursement rates to physicians, which will probably motivate some physicians to retire early or seek other opportunities outside of medicine. This erosion of the physician workforce would also negatively impact the quality of health care offered to California patients.

Reduction in Health Care Affordability

A growing number of studies demonstrate that health plan mergers do not result in lower costs to patients.[7] That is, the promise to use their increased market power, or monopsony power, to negotiate lower reimbursement rates from providers does not translate into lower premiums or lower deductibles for patients. Instead, a growing body of peer-reviewed literature suggests that greater consolidation amongst health plans leads to price increases and access disruptions.[8] A review of past mergers demonstrates that competition in the health insurer market, not consolidation, is the right prescription for patients. The AMA has found that in markets with healthy competition, patient premiums are lower; plans are incentivized to enhance customer service, pay bills accurately and on time, and develop and implement innovative ways to improve quality while lowering costs.[9]

Loss of Collaboration and Innovation

One driver behind health care reform and value based health care is to incentivize collaboration in health care markets in order to increase innovation and reduce costs. When examining recent mergers, industry

---

[6] See, e.g., Letter from James L. Madara, M.D., Exec. Vice President, American Medical Association, to William Baer, Assistant Attorney General, U.S. Dept. of Justice Antitrust Division (November 11, 2015)(on file with the California Medical Association).

[7] *See, e.g.,* Thomas Greaney, *Examining Implications of Health Insurance Mergers*, Health Affs. (July 16, 2015); Leemore Dafny et al., *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*, 102 Am. Econ. Rev. 1161 (2012); Jose Guardado, et al., *The Price Effects of a Larger Merger of Health Insurers: A Case Study of United-Sierra*, 1(3) Health Management, Policy and Innovation 1 ; Robert Pear, *Many Say High Deductibles Make Their Health Law Insurance All but Useless*, N.Y.Times (Nov. 14, 2015); David Lazarus, *As Health Insurers Merge, Consumer's Premiums Are Likely to Rise*, L.A. Times (July 10, 2015); Leemore Dafny, *Are Health Insurance Markets Competitive?*, 100 Am. Econ. Rev. 1399 (2010).

[8] *See* Statement of the American Medical Association and California Medical Association to the California Department of Insurance re: Anthem Application for the Proposed Acquisition of Cigna (March 29, 2016).

[9] Letter from James L. Madara, M.D., Exec. Vice President, American Medical Association, to William Baer, Assistant Attorney General, U.S. Dept. of Justice Antitrust Division (November 11, 2015)(on file with the California Medical Association).

experts have expressed concern that if insurers have too much market power then they have no reason to collaborate with health care providers.[10] California physicians have experienced this effect already in California markets where health insurers do not negotiate with solo and small group physicians but instead offer them take-it-or-leave contracts. While health insurers assert that their exercise of such market power results in lower provider reimbursement rates, such savings do not benefit the patient because history demonstrates that any such savings are not passed down in cost savings to the patients, patients lose access to their physicians who are driven out of the network, and the opportunity to "collaborate" with physicians to provide innovative, quality health care is lost. Accordingly, the CMA urges the CDI to thoroughly review and research whether there is any independent evidence supporting the health plans' claims that mergers lead to greater efficiencies and innovative payment and care management programs. Fostering competition between Aetnaand Humana, not consolidation, will benefit California patients through lower prices, better quality and greater choice.

Conclusion

Accordingly, the CMA urges the CDI to carefully review and consider its recommendation in regards to the proposed Aetna-Humana merger in order to protect patients from premium increases, lower health plan capacity and physician collaboration, and a reduction in the quantity and quality of physician services. We thank the CDI for considering the impact the proposed Aetna-Humana merger would have on California and look forward to working with you further on this issue.

Sincerely,

Francisco J. Silva

General Counsel and Senior Vice-President
Centers for Legal Affairs, Health Policy, & Economic Services

FJS:mr
Encl.

[10] Reed Abelson, *With Merging of Insurers, Questions for Patients About Costs and Innovation*, N.Y. Times (July 5, 2015).

CMA Survey Shows Strong Physician Opposition to Health Insurer Market Consolidation

March 28, 2016

Proposed mergers of the some of the largest national health insurers have been announced, against the backdrop of an already highly concentrated commercial health insurance market. With Aetna's proposal to acquire Humana for $37 billion and Anthem's proposal to acquire Cigna for $48.4 billion, the "big five" health insurers will become the "big three."

The California Medical Association has long been concerned with the consolidation of health plans and health insurers and the reduction of competition. Physicians across the country have serious concerns with the proposed mergers' impact on patients in terms of health care access, quality and affordability.

A recent American Medical Association (AMA) analysis of data from the 2015 update to its "Competition in Health Insurance: A comprehensive study of U.S. markets," demonstrates that an Anthem-Cigna merger would be "presumed likely to enhance market power" in the combined HMO+PPO+POS commercial markets in 10 of the 14 states in which Anthem is licensed to provide commercial coverage. In California, the report identified nine metropolitan statistical areas (MSAs) where the Anthem-Cigna merger will be "presumed likely to enhance market power" and six MSAs where the merger "potentially raises significant competitive concerns." Click here to see the map and here to see CMA's letter to DMHC opposing the Anthem-Cigna merger.

Accordingly, CMA, in collaboration with the AMA, conducted a survey to gauge California physicians' perspective on the Anthem-Cigna and Aetna-Humana mergers, and gather data on how physicians currently negotiate with insurance companies. In a brief period of time, CMA received one of the highest response rates for such a survey with 989 physician practices responding to the survey.

The survey results suggest that physicians overwhelmingly oppose the mergers. They believe that the mergers would give insurers more influence over physicians' clinical and business practices and would force physicians to cut costs, resulting in a significant degradation of their ability to provide the care patients value and need. The results also indicate that physicians do not believe that the mergers are necessary to gain efficiencies—as insurers claim—in areas such as innovative payment programs and care management strategies that will benefit patients.

Survey Summary

The survey gathered data electronically over a period of 13 days from 989 practices representing physicians across a vast range of specialties and practice sizes in 47 different California counties.

Physicians reject the proposed mergers

- Eighty-five percent of physicians strongly or somewhat oppose the merger of Anthem and Cigna; while 83 percent felt the same with regards to the Aetna and Humana merger.

- Most respondents believe the Aetna-Humana (76 percent) and Anthem-Cigna (83 percent) mergers would make the contracting negotiation process less favorable.

- Currently, almost one-third of practices report difficulty finding available in-network physicians who accept new patients from these four payors and 44 percent of practices experience problems with formulary limitations that prevent optimal treatment.

Negative consequences if the mergers are approved

- Eighty-two percent believe the Anthem-Cigna merger is very or somewhat likely to lead to narrower physician networks, which will reduce access to patient care; while 78 percent feel the same with regards to the Aetna-Humana merger.

- More than 75 percent of physicians believe they will be pressured not to engage in aggressive patient advocacy if either of the mergers are approved.

- Almost 90 percent of respondents believe that it is either very likely or somewhat likely that reimbursement rates will decrease and the result will be a reduction in the quality and quantity of services physician can provide to their patients.

- Eighty-three percent of physicians report they disagreed or strongly disagreed that the mergers are necessary to gain efficiencies.

- Eighty-four percent of respondents believe that if the mergers are approved, insurers will have even more influence over physician practices and they will be forced to cut costs, which will result in a significant degradation of their ability to provide the care that patients value and need.

- Physicians report if the mergers are approved and the doctor does not continue to have a contract with the merged plan(s) they would be forced to cut staff and salaries, reduce investment in practice infrastructure, spend less time with patients, cut quality initiatives, close their practice and/or retire.

- If the insurance mergers proceed and decision-makers decided not to contract with the merged health plan, the following consequences were reported:

If Aetna-Humana merged:

- 12% would retire from active practice
- 9% would need to close their practice
- 6% would move their practice to a more competitive reimbursement market
- 32% would cut investments in practice infrastructure
- 37% would cut or reduce staff salaries
- 30% would have to spend less time with patients
- 24% would cut quality initiatives or patient services

If Anthem-Cigna merged:

- 13% would retire from active practice
- 15% would need to close their practice
- 8% would move their practice to a more competitive reimbursement market
- 31% would cut investments in practice infrastructure
- 40% would cut or reduce staff salaries
- 43% would have to spend less time with patients
- 27% would cut quality initiatives or patient services

Current market power of commercial insurers over physicians

- Fifty-four percent of respondents felt that they *had to* contract with Aetna in order to have a financially viable practice; nearly 30 percent felt that way with respect to Humana. Seventy-one percent felt that they *had to* contract with Anthem and 47 percent felt that way with respect to Cigna. When asked why commercial insurers were essential to the financial viability of their practices, responses clustered into the following categories:
  - High market shares of insurers
  - Volume of and access to patients
  - To offset losses from government health plans

- Only 10 percent of respondents said that they could turn away from a commercial insurer and recover lost revenue by treating more Medicare or Medi-Cal patients

- Thirty-two percent of respondents who are contracted with Anthem reported difficulty finding available in-network physicians who accepted new patients for referrals. Twenty-six percent of respondents who are contracted with Cigna reported similar experiences.

- Fifty-three percent of respondents who are contracted with Anthem encountered formulary limitations which prevented a patient's optimal treatment. Forty-two percent of respondents who are contracted with Cigna reported similar experiences.

- Respondents encountered challenges with the adequacy of provider networks including:
  - Limited choices for facilities contracted under a plan
  - Prior authorizations and narrow networks

- Sixty-six percent and 45 percent of practice decision-makers[1] who are contracted with Anthem and Cigna, respectively, reported that contracts were "take-it-or-leave-it" offers. Fifty-eight percent of practice decision-makers had seen an "all-products" clause in an offered health plan.

- Forty-one percent of decision-makers were offered a single contract for different types of plans; 20 percent were offered separate contracts with different terms for different types of offered plans.

- Twenty-three percent of decision-makers were paid the same fees across different types of plans offered; 45 percent were offered different fees for different plans.

[1] A "decision-maker" is a respondent who reported that they were the primary decision maker or one of a group of decision makers in their practice. In this survey, the total number of decision-makers was 367.

Detailed Survey Results

Introduction

1. Please indicate your type of practice:

Employee in a small to medium sized single or multi-specialty practice	5.6%
Employee in a large single or multi-specialty practice	5.6%
Employee of a private hospital	0.9%
Employee of a public hospital	0.7%
Employee of an integrated health delivery system (e.g., Kaiser)	3.0%
Employee of a teaching hospital/Academic center	3.9%
Government/military employee	2.0%
Administrative	2.6%
Resident/Fellow	1.8%
Medical student	1.0%
Retired	5.0%
Other (please specify)	3.5%

2. Which of the following types of insurance do you or your employer currently contract with? (Check all that apply.)

Commercial insurance	86.4%
Fee for Service Medicare	71.8%
Medicare Advantage	56.0%
Medi-Cal	52.5%
Not sure	3.4%
Other	13.5%

3. Which of the following insurers do you or your employer currently contract with? (Check all that apply.)

Aetna	78.0%
Anthem	84.5%
Cigna	74.8%
Humana	49.8%
Kaiser Permanente	13.9%
United Healthcare	75.7%
Tricare/military	59.8%
Not sure	6.8%
Other commercial plan	20.8%

Experience with Commercial Payers

4. Approximately what percentage of your practice revenues are derived from the following?

	Aetna	Anthem	Cigna	Humana	United Healthcare
0-10%	71.9%	32.6%	80.6%	90.3%	60.0%
11-25%	26.0%	39.0%	18.0%	8.4%	32.0%
26-49%	1.0%	19.6%	1.0%	0.9%	6.0%
50-75%	1.0%	7.1%	0.2%	0.2%	1.0%
76-100%	1.0%	1.7%	0.2%	0.2%	1.0%

5. Do you feel that you must contract with one or more of the following commercial insurers in order to have a financially-viable practice? (Check all that apply.)

Aetna	53.5%
Anthem	70.8%
Cigna	47.1%
Humana	29.5%
United Healthcare	53.8%
Other commercial plan	34.0%
None of these	10.7%
Not sure	16.2%

6. What makes these insurers essential to your financial viability?

Comments (sample)

- Patients choose providers who are listed in their network. It's a financial decision for them as well.
- They control the market. If you are not part of their PPO network, patients will go to a provider who is part of their network
- We would go out of business without Anthem and UHC
- They have large market share
- The physicians who refer to me contract with them
- The majority of patients in my area have one of these insurance carriers
- We care for a large number of patients with urgent trauma related problems. We need to be contracted with these insurers in order to expedite their care
- They insure a significant number of locals and I depend upon their referrals, especially Anthem Blue Cross
- Retain current patients
- Most patients have these insurances
- The majority of the patients that present to the office are insured by these big 4 payers
- BC & BS comprise 95% of commercial business in my area and are the only Covered California plans
- We would lose sufficient business that we could not meet payroll and cover other expenses
- Blue Cross and Blue Shield have the most lives in the Fresno area through direct contracts and network leasing agreements
- Without them, not enough patients to be financially viable
- We try to accept as many insurers as possible to accommodate our hospital mix of patients
- They are big and have multiple affiliations with other insurers- not signing with one takes me off multiple insurers
- Every patient counts
- Viability of my practice

- 80% of covered lives in our area are covered by Anthem Blue Cross
- I am forced to contract with them because of their large market share despite the fact that they refuse to negotiate their inadequate payments to physicians
- The hospital I take call with is contracted with these companies
- Helps balance the budget with our large Medi-Cal, underinsured, uninsured population

7. Do you agree or disagree with this statement: If you are unhappy with fees from an insurer, you can choose to turn away from that insurer and recover the lost revenue by treating more Medicare and Medi-Cal patients.

Strongly agree	3.9%
Somewhat agree	6.5%
Neither agree nor disagree	6.1%
Somewhat disagree	13.6%
Strongly disagree	**68.8%**
Not sure	1.0%

Narrow Networks

8. If you are contracted with Aetna, Anthem, Cigna or Humana, please indicate with respect to each whether you have encountered any of the following (Check all that apply):

	Difficulty finding available in-network physicians who accept new patients for referrals	Formulary limitations which prevent optimal treatment	N/A or not sure
Aetna	27%	45%	48%
Anthem	32%	53%	38%
Cigna	27%	42%	50%
Humana	23%	36%	58%

9. Have you encountered other challenges regarding the adequacy of provider networks?

No	45.8%
Yes	54.2%

Comments (sample)

- The online networks are inaccurate regarding participating physicians and hospitals
- Networks are too narrow to provide good care. Physicians/specialists with the best outcomes are often not contracted. The health plans then look to contract lower quality of care physicians due to cost. Patients have no options. PCP's have no options.
- Prior approval on drugs or scans or procedures.
- Limited contracts with pediatric specialists, reimbursement for vaccines and related costs barely solvent.
- We wrestle with getting authorizations for surgeries from these insurers. This leads to delay in care which can affect patient outcomes. In our community there are limited numbers of specialists so patients cannot just choose to seek care from another provider.
- Many times when I call to get prior authorizations for surgery, I am talking to someone off shore and they are very hard to understand. It sometimes takes over an hour to get authorizations. When I try to call them with questions I am on hold for more than 1/2 waiting for someone.

- Very limited psychiatric and drug treatment/addiction services.
- Pre authorization requirements and requests for medical records have increased dramatically. Reimbursement rates not at all keeping up demands placed upon practices.
- As a surgeon, I have encountered difficulty getting certain surgical procedures approved. Many procedures using relatively newly FDA approved devices are denied as "experimental", including some that are covered by Medicare. Even if covered, if any deviation from the "on-label" indication is needed for a patient, it will virtually never be approved.
- Ensuring patients are able to be treated at our hospital of choice. They need to be admitted elsewhere since they're out-of-network and their co-pays are astronomical at our hospital of choice.
- It is still not always clear if patients belong to a narrow network (Anthem). Patients do not know that they belong to a narrow network.
- My patients have had to travel to providers hours away.
- We do not have a lot of specialty depth in our county and finding specialists for patients in network has become increasingly more difficult, particularly in areas like pain management, endocrinology, rheumatology and ENT.
- Patient dissatisfaction
- Patients complain that their previous plans did not have any doctors for them t see, so they switched to Kaiser.
- Frequent changes in panel of authorized specialists to include less capable ones; lack of relationship or communication with them; authorization of specialists that are far away rather than specialists closer to me and my patients.
- Harder to get certain testing completed.
- Increasing limitations on referrals
- Dead physicians listed as participating providers!
- Very poor availability of pediatric specialists
- Over burdensome approval processed, limitation of care able to be provided
- All these plans will NOT negotiate rates, many will not offer me a contract, and most will not allow me on the exchange product, even though as a pediatric ophthalmologist our group is the ONLY group servicing 9 of the hospitals they contract with and there are no other full time peds ophthalmology groups within 40 miles to the west, and 200 miles to the east of our group.
- Their provider lists are hopelessly inaccurate.

Negotiation Process

10. Which of these best describes your role in negotiating contracts with insurance companies?

You are the primary decision maker	38.6%
You are one of a group of decision makers	19.7%
You are aware and might give input, but do not participate in the process	11.1%
You are generally not involved in these negotiations	25.8%
Other	4.8%

11. **Negotiation Process: For the most recent contract, did any of the following payers give you a "take it or leave it" offer, versus being allowed to participate in a two-way bargaining process? (Check all that apply.)**

Aetna	48.3%
Anthem	66.2%
Cigna	45.1%
Humana	31.2%
Not sure	13.6%
None of these	15.0%

12. **Some insurers may negotiate different physician contract terms for the different types of insurance plans that they offer (e.g. Medicare Advantage, commercial group health insurance, commercial insurance plans sold to individuals, HMO-type products, PPO and indemnity products etc.). Other insurers may negotiate one contract that covers all of the insurance plans they offer. (Check which of these two contracting approaches applies to each of the merging insurers.)**

	Offered only a single contract	Offered separate contracts	Don't know	N/A
Aetna	45%	20%	25%	10%
Humana	31%	12%	33%	25%
Anthem	45%	30%	18%	6%
Cigna	43%	17%	28%	12%

13. **Are you paid the same fees across the different types of insurance plans the insurer offers?**

	Yes	No	Don't know	N/A
Aetna	27%	45%	18%	10%
Humana	18%	37%	22%	23%
Anthem	26%	54%	14%	6%
Cigna	23%	44%	22%	12%

14. **Have you ever seen an "all-products clause," defined as follows: An "all-products clause" is a clause in a health plan's physician contract that requires, as a condition of participating in any of the health plan products, that the physician participate in all of the health plan products?**

Have seen these in contract negotiations with a commercial payer	57.5%
Have not seen an all products clause in negotiations with a commercial payer	11.8%
Not sure	30.6%

Factors Affecting Negotiations

15. How often are reimbursement rates paid by other commercial insurers referenced by the health insurer in negotiations (to negotiate lower rates by comparing to a competitor's lower rates)?

Every negotiation	9.9%
Most of the time	17.2%
About half of the time	4.9%
Sometimes	10.2%
Rarely	14.2%
Never	14.8%
Not sure	28.8%

Comparing Individual Mergers

16. How do the contract terms with Anthem compare to the contract terms with other commercial insurers?

Much more favorable for you as a physician	2.7%
Somewhat more favorable	11.3%
About the same	23.8%
Somewhat less favorable	19.9%
Much less favorable	32.7%
Not sure	6.5%
N/A	3.0%

17. How do the contract terms with Aetna compare to the contract terms with other commercial insurers?

Much more favorable for you as a physician	5.4%
Somewhat more favorable	14.0%
About the same	30.7%
Somewhat less favorable	17.0%
Much less favorable	15.8%
Not sure	11.0%
N/A	6.3%

18. How do the contract terms with Cigna compare to the contract terms with other commercial insurers?

Much more favorable for you as a physician	6.0%
Somewhat more favorable	14.3%
About the same	30.7%
Somewhat less favorable	15.2%
Much less favorable	14.6%
Not sure	11.0%
N/A	8.3%

19. How do the contract terms with Humana compare to the contract terms with other commercial insurers?

Much more favorable for you as a physician	1.5%
Somewhat more favorable	7.1%
About the same	23.8%
Somewhat less favorable	11.0%
Much less favorable	14.3%
Not sure	21.1%
N/A	21.1%

Insurance Company Consolidation – Likely effects of mergers

20. In your view, how would the merger of Aetna and Humana impact the process of contract negotiations?

Much more favorable for you as a physician	0.9%
Somewhat more favorable	3.0%
No impact	6.0%
Somewhat less favorable	16.7%
Much less favorable	59.4%
Not sure	9.3%
Need to wait and see	4.8%

21. How would the merger of Anthem and Cigna impact on the process of contract negotiations?

Much more favorable for you as a physician	1.8%
Somewhat more favorable	3.0%
No impact	3.9%
Somewhat less favorable	15.8%
Much less favorable	67.2%
Not sure	5.7%
Need to wait and see	2.7%

22. What, if anything, would you do if Aetna and Humana merged and you did not continue to have a contract with the merged health plan? (Choose all that apply, and comment as needed.)

Do not expect a significant impact (Check as your only response, please)	16.8%
Retire from active practice	11.4%
Would need to close my practice	9.0%
Move my practice to another locale with a more competitive reimbursement market	6.0%
Would cut investments in practice infrastructure (technology, etc.)	31.5%
Would cut staff or reduce salaries	36.9%
Would need to spend less time with patients	30.0%
Would cut quality initiatives or patient services (labs, radiology, case management, etc.)	24.3%
Not sure	19.2%

Other (please specify)	20.4%

Other (sample)

- I would consider a fee for service practice
- The margin is so thin that the merger would devastate my practice and I absolutely would no longer be able to provide the quality care I do now.
- Begin a process of phasing out all insurance
- Downsize
- I would plan to cut the number of days I see patients
- May close doors to new patients
- Work fewer hours per week, lay off staff
- Pay my salary doctors less, which would be very bad
- This would force patients to drive long distances to receive a liver transplant. Many patients cannot do this, and will die.
- Access to our transplant program by patients would be severely limited
- Might have to be out of network resulting in the patients getting balance billed
- I would either move to cash only structure, for those patients with this insurance who still wish to be seen, or just see Medicare patients. If this doesn't work out, I would retire from practice.
- Leave medicine entirely

23. What, if anything, would you do if Anthem and Cigna merged and you did not continue to have a contract with the merged health plan? (Choose all that apply, and comment as needed.)

Do not expect a significant impact (Check as your only response, please)	8.7%
Retire from active practice	13.4%
Would need to close my practice	15.2%
Move my practice to another locale with a more competitive reimbursement market	8.1%
Would cut investments in practice infrastructure (technology, etc.)	30.7%
Would cut staff or reduce salaries	40.0%
Would need to spend less time with patients	34.3%
Would cut quality initiatives or patient services (labs, radiology, case management, etc.)	26.3%
Not sure	18.8%
Other (please specify)	20.3%

Other (sample)

- If would bankrupt me. Anthem pays 47% less than other payors
- Downsize
- Reduce number of days I see patients
- Would seriously consider retiring or closing practice.
- I would either move to cash only structure, for those patients with this insurance who still wish to be seen, or just see Medicare patients. If this doesn't work out, I would retire from practice.
- Will align with hospital
- Go out of network, which would limit access
- Convert to fee for service only

Insurance Company Consolidation: Likely effects of Aetna-Humana Merger

24. Narrower physician networks will reduce patient access to care.

Very likely	58.0%
Somewhat likely	19.6%
Neither likely nor unlikely	5.7%
Somewhat unlikely	5.4%
Very unlikely	3.3%
Not sure	7.9%

25. Reimbursement rates for physicians will decrease such that there would be a reduction in the quality and quantity of the services that physicians are able to offer patients.

Very likely	70.7%
Somewhat likely	19.0%
Neither likely nor unlikely	3.9%
Somewhat unlikely	1.2%
Very unlikely	0.9%
Not sure	4.2%

26. Physicians will be pressured not to engage in aggressive patient advocacy, a crucial safeguard of patient care.

Answer Options	Response Percent
Very likely	55.0%
Somewhat likely	23.6%
Neither likely nor unlikely	6.9%
Somewhat unlikely	2.4%
Very unlikely	4.2%
Not sure	7.9%

Insurance Company Consolidation: Likely effects of Anthem-Cigna merger

27. Narrower physician networks will reduce patient access to care.

Answer Options	Response Percent
Very likely	66.2%
Somewhat likely	16.0%
Neither likely nor unlikely	7.6%
Somewhat unlikely	3.3%
Very unlikely	3.0%
Not sure	3.9%

28. Reimbursement rates for physicians will decrease such that there would be a reduction in the quality and quantity of the services that physicians are able to offer patients.

Answer Options	Response Percent
Very likely	72.5%
Somewhat likely	16.3%
Neither likely nor unlikely	4.2%
Somewhat unlikely	1.5%
Very unlikely	2.4%
Not sure	3.0%

29. Physicians will be pressured not to engage in aggressive patient advocacy, a crucial safeguard of patient care.

Answer Options	Response Percent
Very likely	59.8%
Somewhat likely	22.1%
Neither likely nor unlikely	6.6%
Somewhat unlikely	0.6%
Very unlikely	4.2%
Not sure	6.6%

Insurance Company Consolidation – Attitudes towards the mergers

30. Anthem has proposed to acquire Cigna. Do you support or oppose regulators allowing this merger to proceed?

Strongly support allowing merger to proceed	1.7%
Somewhat support	2.5%
Neither support nor oppose	6.0%
Somewhat oppose	10.3%
Strongly oppose allowing mergers to proceed	74.9%
Not sure	4.6%

31. Aetna has proposed to acquire Humana. Do you support or oppose regulators allowing this merger to proceed?

Strongly support allowing merger to proceed	1.4%
Somewhat support	2.4%
Neither support nor oppose	8.2%
Somewhat oppose	11.1%
Strongly oppose allowing mergers to proceed	71.7%
Not sure	5.2%

Insurance Company Consolidation: Likely effects of mergers – alleged merger efficiencies & costs

32. Efficiencies. Do you agree or disagree with the following statement? The mergers are necessary to gain efficiencies in areas such as innovative payment programs and care management strategies that will benefit patients.

Strongly disagree	60.9%
Disagree	22.1%
Neither agree nor disagree	10.6%
Agree	3.3%
Strongly agree	3.1%

33. Costs. Do you agree or disagree with the statement that these mergers will give those insurers even more influence over physicians' clinical and business practices with little or no recourse for physicians? Physicians will be forced to cut costs so deeply that we will see a significant degradation of their ability to provide the care that patients value and need.

Strongly disagree	8.2%
Disagree	2.6%
Neither agree nor disagree	5.1%
Agree	16.5%
Strongly agree	67.7%

Wrap Up

34. Do you have any stories or experiences that you think are particularly compelling examples of concerns you have about these mergers between Aetna-Cigna and Anthem-Humana?

Comments (sample)

- Obviously, mergers are not necessary for innovation and efficiency to occur. Mergers remove the crucial element of the free-market, that is, healthy competition. Consumers, and physicians, will bear the brunt of these types of large mergers.
- Bottom line is this as these companies merge it will be even tougher for doctors to practice medicine in private practice period.
- Reflect upon past instances where consolidation has resulted in fewer choices for patients and later reductions in physician payments for services provided to patients.
- It`s tantamount to price fixing and unilaterally determining what is too be paid; the system needs competition to be successful
- The bigger the corporation, the less responsive to concerns of and payment to physicians as well as less accommodating to patients.
- Historically most mergers have been disastrous for patients/providers and beneficial for a few superrich CEO's or owners.
- Clearly the history of mega mergers in any industry has consistently resulted in less choices and more cost for their customers. Health care is no exception and this will result in less access to care and more profits for insurance companies.
- Insurance companies are routinely denying coverage of needed medications for my patients. That situation will only get worse with mergers.
- I am concerned that Anthem is gaining too much control in the medical insurance industry. Many facilities and providers are no longer contracting with Anthem because they reimburse poorly and do not pay claims fairly

- The insurance companies are already too big. We stopped contracting with Anthem, because they would drop our reimbursements each year by a few % without negotiation. These mergers will make it worse. Allowing these mergers will make it impossible for private practice docs to negotiate rates adequate to pay overhead.
- Yes, insurance companies have too much power over how medicine in practiced.
- The plans are becoming too big to fail. They intentionally ask for more and more before paying and we have no recourse. They continue to cut reimbursements and ask for authorization as though they have the MD , yet they've no liability
- I thought Monopolies were illegal in America
- It's simple. Bigger equals more leverage. Less willing to negotiate. Providers are never in the best position and we cannot unionize or fight it. At least with Medicare you have a representative or someone who's supposed to impartial. Here there is no arbitration or someone who is looking out for best interests of the providers and patients.
- They will completely destroy what is left of independent practice
- We might as well a single payer system with all of its inefficiencies.
- When United Health care merged about 10 years ago, they cut reimbursement rates and embarked on many actions that were unfavorable to patient care and physician advocacy
- Patients will lose all autonomy and choice. They will suffer the most. I have many stories of patients who are miserable with Anthem.

Medicare Advantage markets where an Aetna-Humana merger warrants antitrust scrutiny

Analysis of data from HealthLeaders-InterStudy's Managed Market Surveyor 2013

Health Policy Group
American Medical Association

This report examines the effects of a proposed merger between Aetna and Humana on market concentration (HHI) in Medicare Advantage markets. The data source is HealthLeaders-InterStudy's Managed Market Surveyor 2013, which, in turn, obtained the data from the Centers for Medicare & Medicaid Services (CMS).[1] Using the 2010 Department of Justice/Federal Trade Commission *Horizontal Merger Guidelines*, this report presents the state and metropolitan statistical area (MSA) level markets where the merger would raise competitive concerns based on how the guidelines classify markets. Under the DOJ/FTC merger guidelines:

- MSAs with an HHI less than 1,500 are *unconcentrated*; mergers are unlikely to raise competitive concerns.
- MSAs with an HHI between 1,500 and 2,500 are *moderately concentrated*; mergers that increase the HHI by more than 100 points potentially raise significant competitive concerns and often warrant scrutiny.
- MSAs with an HHI of more than 2,500 are *highly concentrated*; mergers that increase the HHI by 100 to 200 points potentially raise significant competitive concerns and often warrant scrutiny, and those that increase it by more than 200 points will be presumed likely to enhance market power.

The following set of tables reports those markets' pre- and post-merger HHIs and the change in HHIs that would result from the proposed merger. The results are reported at the state level and then by MSA. All results pertain to Medicare Advantage product markets.

Tables 1 and 3 list those states and MSAs where such a merger would be presumed likely to enhance market power according to the guidelines above (i.e., combination of a highly concentrated market and a significant increase in the HHI). Those are the markets that would be expected to be most adversely affected by the merger.

Tables 2 and 4 list those states and MSAs where such a merger potentially raises significant competitive concerns and often warrants scrutiny (i.e., combination of moderately to highly concentrated market and a meaningful increase in the HHI).

The results in Table 1 indicate that an Aetna-Humana merger would be presumed likely to enhance market power in Medicare Advantage markets in the states of Arkansas, Georgia, Illinois, Iowa, Kansas, Maine, Missouri, Nebraska, Nevada, North Carolina, Ohio, South Dakota, Texas, Utah, Virginia and West Virginia.

The results in Table 2 indicate that an Aetna-Humana merger potentially raises significant competitive concerns and often warrants scrutiny in three additional states (Florida, Oklahoma and Pennsylvania).

Although Tables 1 and 2 show that the merger would cause large increases in market concentration (HHI), we note that in a few of the states listed in those tables

1 HLI obtained the data from CMS. We exclude carriers providing HCPP, PACE, employer-only and SNP-only plans.

(Arkansas, Nevada, Oklahoma, Pennsylvania, Virginia and West Virginia) Aetna's (or in the case of Pennsylvania, Humana's) pre-merger market shares were not that high (i.e., below 5 percent). In those states, the significant increases in the HHI would be the result of the high shares of one of the two merging insurers (usually Humana).

Turning to the analysis by MSA, the results presented in Table 3 indicate that an Aetna-Humana merger would be presumed likely to enhance market power in MSAs located in 21 states (Arkansas, California, District of Columbia, Florida, Georgia, Illinois, Iowa, Kansas, Maine, Maryland, Missouri, Nebraska, Nevada, North Carolina, Ohio, Pennsylvania, South Dakota, Texas, Utah, Virginia and West Virginia).

Finally, the results in Table 4 indicate that an Aetna-Humana merger potentially raises significant competitive concerns and often warrants scrutiny in MSAs in 10 states (Arkansas, Florida, Georgia, Illinois, North Carolina, New York, Ohio, Pennsylvania, Tennessee and Texas).

We note that although all MSA-level results presented here show the merger would cause significant increases in market concentration (HHI), in some MSAs listed in those tables Aetna's (or Humana's) pre-merger shares were not that high (i.e., below 5 percent), particularly among some MSAs in Table 4. In those MSAs, the significant HHI changes are the result of the high shares of one of the two merging insurers.

Table 1. State-level markets where Aetna-Humana merger will be presumed likely to enhance market power

State	Medicare Advantage HHI		Change in HHI
	Pre-merger	Post-merger	
Kansas	4152	8064	3912
Missouri	2610	3930	1320
Iowa	2929	4166	1238
Illinois	2321	3513	1192
Ohio	1864	2767	904
Nebraska	4213	5111	899
South Dakota	4420	5035	615
Texas	2115	2728	614
Maine	2835	3368	533
West Virginia	5626	6056	430
Utah	3466	3782	316
Arkansas	2628	2934	305
Virginia	3956	4225	269
Georgia	3873	4131	258
Nevada	3597	3850	252
North Carolina	3019	3258	239

Table 2. State-level markets where Aetna-Humana merger potentially raises significant competitive concerns and often warrants scrutiny

State	Medicare Advantage HHI		Change in HHI
	Pre-merger	Post-merger	
Florida	1956	2314	358
Pennsylvania	1889	2016	127
Oklahoma	2824	2924	100

Table 3. MSA-level markets where Aetna-Humana merger will be presumed likely to enhance market power

State and MSA	Medicare Advantage HHI		Change in HHI
	Pre-merger	Post-merger	
Arkansas			
Hot Springs, AR	2996	4370	1374
Fayetteville-Springdale-Rogers, AR-MO	3339	4065	726
Fort Smith, AR-OK	3173	3652	479
California			
Fresno, CA	3132	3410	278
District of Columbia			
Washington-Arlington-Alexandria, DC-VA-MD-WV	3945	4292	347

State and MSA	Medicare Advantage HHI		Change in HHI
	Pre-merger	Post-merger	
Florida			
Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	3097	4020	923
Port St. Lucie-Fort Pierce, FL	2099	2945	846
West Palm Beach-Boca Raton-Boynton Beach, FL	3813	4539	725
Tampa-St. Petersburg-Clearwater, FL	2325	2720	396
Naples-Marco Island, FL	3184	3529	345
Jacksonville, FL	2584	2882	297
Georgia			
Brunswick, GA	3979	4849	870
Savannah, GA	3073	3592	519
Atlanta-Sandy Springs-Marietta, GA	2931	3314	383
Macon, GA	5239	5453	214
Illinois			
Rockford, IL	4765	9518	4754
Springfield, IL	3777	5869	2092
Peoria, IL	4204	5435	1231
Lake County-Kenosha County, IL-WI	5741	6703	962
Chicago-Naperville-Joliet, IL	2645	3488	843
Bloomington-Normal, IL	4006	4735	729
Davenport-Moline-Rock Island, IA-IL	4750	5382	632
Iowa			
Cedar Rapids, IA	3918	6237	2319
Sioux City, IA-NE-SD	3942	6172	2230
Iowa City, IA	3388	5429	2041
Des Moines, IA	3742	5000	1258
Waterloo-Cedar Falls, IA	5574	5847	273
Kansas			
Wichita, KS	5040	9781	4740
Topeka, KS	5061	8345	3283
Maine			
Bangor, ME	2952	3626	674
Lewiston-Auburn, ME	4048	4690	642
Portland-South Portland, ME	2518	3128	610
Maryland			
Hagerstown-Martinsburg, MD-WV	3408	6255	2847
Missouri			
Joplin, MO	3686	7152	3466
Kansas City, MO-KS	3698	6995	3297
Jefferson City, MO	3495	6217	2722
Springfield, MO	3154	4909	1755
Columbia, MO	2903	3730	827
St. Louis, MO-IL	2848	3118	270

State and MSA	Medicare Advantage HHI		Change in HHI
	Pre-merger	Post-merger	
Nebraska			
Lincoln, NE	5243	9215	3973
Omaha-Council Bluffs, NE-IA	4625	5320	695
Nevada			
Las Vegas-Paradise, NV	4262	4574	312
North Carolina			
Hickory-Morganton-Lenoir, NC	2546	3762	1216
Wilmington, NC	4187	4892	705
Raleigh-Cary, NC	2607	3237	629
Durham, NC	2713	3230	518
Charlotte-Gastonia-Concord, NC-SC	2988	3204	217
Ohio			
Sandusky, OH	3213	5825	2612
Mansfield, OH	3075	4948	1872
Lima, OH	3456	5291	1835
Toledo, OH	2594	3925	1331
Springfield, OH	2836	3970	1134
Columbus, OH	2300	3425	1125
Cleveland-Elyria-Mentor, OH	2207	2949	742
Cincinnati-Middletown, OH-KY-IN	2641	3352	710
Weirton-Steubenville, WV-OH	2245	2733	488
Akron, OH	2029	2509	480
Dayton, OH	2704	3161	456
Canton-Massillon, OH	2330	2619	289
Pennsylvania			
Lancaster, PA	2625	3442	817
Williamsport, PA	2368	3056	688
Lebanon, PA	3563	4127	564
Harrisburg-Carlisle, PA	2803	3254	451
Scranton--Wilkes-Barre, PA	3275	3592	317
Reading, PA	2344	2593	249
York-Hanover, PA	2320	2562	242
South Dakota			
Sioux Falls, SD	4069	5038	969
Texas			
Wichita Falls, TX	3410	6092	2682
Midland, TX	3354	5815	2461
Victoria, TX	3749	6147	2398
Amarillo, TX	3496	5787	2291
Abilene, TX	3171	5429	2258
Odessa, TX	3335	5164	1828
San Angelo, TX	2787	4608	1821
Sherman-Denison, TX	2843	4587	1744
Texarkana, TX-AR	3603	5340	1737
Longview, TX	2737	4253	1516
Austin-Round Rock, TX	3231	4645	1414

Medicare Advantage markets where an Aetna-Humana merger warrants antitrust scrutiny

State and MSA	Medicare Advantage HHI		Change in HHI
	Pre-merger	Post-merger	
Tyler, TX	2984	4342	1358
Laredo, TX	2501	3735	1233
College Station-Bryan, TX	2852	4027	1175
Lubbock, TX	2260	3420	1160
Waco, TX	2853	3688	835
San Antonio, TX	3552	4138	585
Dallas-Plano-Irving, TX	3581	4114	534
McAllen-Edinburg-Mission, TX	2860	3342	482
Corpus Christi, TX	4475	4951	476
Beaumont-Port Arthur, TX	2499	2936	436
El Paso, TX	2737	3083	346
Brownsville-Harlingen, TX	3455	3668	213
Utah			
Provo-Orem, UT	3230	3638	408
Salt Lake City, UT	3501	3808	307
Ogden-Clearfield, UT	3745	4039	294
Virginia			
Charlottesville, VA	8962	9747	784
Winchester, VA-WV	8639	9143	504
Virginia Beach-Norfolk-Newport News, VA-NC	6312	6597	285
West Virginia			
Parkersburg-Marietta-Vienna, WV-OH	4079	5596	1516
Charleston, WV	5176	6178	1002
Huntington-Ashland, WV-KY-OH	5446	6354	908
Wheeling, WV-OH	3147	3451	304

Table 4. MSA-level markets where Aetna-Humana merger potentially raises significant competitive concerns and often warrants scrutiny

State and MSA	Medicare Advantage HHI		Change in HHI
	Pre-merger	Post-merger	
Arkansas			
Little Rock-North Little Rock, AR	2454	2638	184
Florida			
Miami-Miami Beach-Kendall, FL	2010	2433	423
Sarasota-Bradenton-Venice, FL	2108	2384	276
Lakeland-Winter Haven, FL	1921	2148	227
Punta Gorda, FL	3520	3655	135
Cape Coral-Fort Myers, FL	3764	3886	122
Pensacola-Ferry Pass-Brent, FL	1997	2117	119
Georgia			
Augusta-Richmond County, GA-SC	4292	4461	169
Illinois			
Danville, IL	5245	5434	189
Champaign-Urbana, IL	5976	6091	115
New York			
Binghamton, NY	2440	2634	194
Syracuse, NY	2075	2180	104
North Carolina			
Burlington, NC	3603	3779	176
Asheville, NC	4018	4184	166
Ohio			
Youngstown-Warren-Boardman, OH-PA	2023	2357	334
Pennsylvania			
Erie, PA	3323	3478	155
State College, PA	3358	3492	134
Philadelphia, PA	3118	3230	111
Tennessee			
Memphis, TN-MS-AR	2270	2375	105
Texas			
Houston-Sugar Land-Baytown, TX	1480	1724	244
Fort Worth-Arlington, TX	4370	4567	197
Killeen-Temple-Fort Hood, TX	5841	5990	149