



January 4, 2016

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

RE: Physicians Advocacy Institute, Inc.'s Concerns Re: Proposed Health Insurer Mergers

Dear Assistant Attorney General Baer:

The Physicians Advocacy Institute ("PAI") appreciates the opportunity to provide comments on the two health insurer mergers before the Department of Justice: Aetna's proposed acquisition of Humana and Anthem's proposed acquisition of Cigna. Physicians and the medical societies that represent them are extremely concerned about the anti-competitive nature of these mergers and the adverse impact on physicians and their patients.

If allowed to proceed, the proposed mergers would result in an unacceptable level of market concentration for commercial and other health insurance markets in several metropolitan areas and states. The resulting power that the remaining three major commercial health insurers would wield would be detrimental not only to physicians and patients, but also to employers and the broader economy. One need only look to the insurers' shareholder communications heralding expectations of higher profits to be concerned.¹ PAI believes these additional profits would accrue at the expense of patients and providers.

I. BACKGROUND ON PAI AND SUMMARY OF CONCERNS ABOUT THE PROPOSED MERGERS

PAI is a 501(c)(6) organization that was founded under the terms of legal settlements reached in class action multidistrict litigation that physicians and nineteen state and county medical societies filed against several of the nation's large for profit health insurers, including Aetna,

¹ See, e.g., <http://betterhealthcaretogether.com>

² The nineteen associations were the Alaska State Medical Association, the California Medical Association, the Connecticut State Medical Society the Denton County Medical Society (TX), the El Paso County Medical Society (CO), the Florida Medical Association, the Medical Association of Georgia, the Hawaii Medical Association, the Louisiana State Medical Society, the Nebraska Medical Association, the

Humana, Anthem, and Cigna (MDL No. 1334, Master File No. 00-1334-MD-Moreno, “the MDL Litigation”). Consistent with these settlements, PAI’s mission is to advance fair and transparent payment polices and contractual practices by health insurance payers in order to sustain the profession of medicine for the benefit of patients. Nineteen state and county medical associations were signatories to the settlement agreements reached in the MDL litigation and several other state and specialty medical societies became additional signatories to the settlement agreements.² The signatory medical societies continue to participate actively in PAI’s advocacy efforts on behalf of physicians and their patients.

PAI’s Board of Directors is comprised of CEOs from nine state medical associations and a lead physician plaintiff from the MDL litigation. The nine state medical societies represented on the PAI Board are California Medical Association, Connecticut State Medical Association, Medical Association of Georgia, Nebraska Medical Association, Medical Society of the State of New York, North Carolina Medical Society, South Carolina Medical Association, Tennessee Medical Association and Texas Medical Association.

Other concerned and interested parties have provided detailed, data-supported analyses of the anticompetitive effects of the proposed mergers. In particular, PAI would point to the November 11, 2015 letter submitted by the American Medical Association (“the AMA”), a copy of which is attached hereto, which provides a comprehensive and compelling assessment of how the proposed mergers would further exacerbate the already highly concentrated health insurance market. The AMA details the negative implications of this market power and urges the Department of Justice to block the proposed mergers. PAI echoes the concerns raised by the AMA and endorses the antitrust analysis outlined by the AMA.

PAI offers additional comments based on its unique insight into the types of unfair market conduct that health insurers have utilized time and again to maximize profits when they have a competitive advantage in the marketplace. The PAI’s position opposing the mergers is informed by the experiences of physicians and medical societies across the nation combatting the egregious health plan payment and contracting policies that compelled the filing of class action, multi-district litigation in the first place.

The increased market power that would result if the mergers are approved would empower the remaining health insurers to raise prices to purchasers of health insurance, structure their insurance product offerings in ways that limit choice and access to specialty care and engage in predatory, unfair contractual and payment practices with physicians. Without competition, there will be no counter-incentive to offset policies that seek to maximize the company’s “bottom line” profits.

This further concentration runs the risk of creating companies that are “too big to fail,” with all the consequences that label entails. The failure of health insurance co-ops under the Affordable

² The nineteen associations were the Alaska State Medical Association, the California Medical Association, the Connecticut State Medical Society the Denton County Medical Society (TX), the El Paso County Medical Society (CO), the Florida Medical Association, the Medical Association of Georgia, the Hawaii Medical Association, the Louisiana State Medical Society, the Nebraska Medical Association, the New Hampshire Medical Society, the Medical Society of the State of New Jersey, the Medical Association of the State of New York, the North Carolina State Medical Society, the South Carolina Medical Association, the Tennessee Medical Association, the Texas Medical Association, and the Washington State Medical Society.

Care Act³ provides a recent example of how patients with serious medical conditions can be left without insurance coverage.

Background information on the MDL litigation and settlements may be of interest as the Antitrust Division analyzes the implications of the proposed acquisitions.⁴

II. HEALTH INSURER ABUSES TARGETED BY THE MDL LITIGATION AND SETTLEMENTS

The first lawsuit in what ultimately became the MDL litigation was filed in 1999. The first settlement agreement was reached with Aetna in 2003 and the last national settlement agreement, with the Blue Cross and Blue Shield Association (“BCBSA”), expired in 2011.

The MDL litigation was brought because physicians across the country, represented by their respective medical associations, reported systematic unfair payment and contracting practices by several major health insurers. These practices were varied in nature but all bore a common trait: they increased health insurers’ profits at the expense of physicians and to the detriment of patient care. Physicians reported that the insurers failed to pay timely and refused to disclose their fee schedule amounts or edits used to calculate payments. Moreover, insurers exercised strong-arm contractual tactics that deprived the physicians of any negotiating ability, resulting in egregiously one-sided contractual provisions, and imposed policies that promoted lower cost treatments for patients.

These day-to-day problems were exemplified in a lawsuit that the Medical Association of Georgia filed in Georgia state court against Blue Cross and Blue Shield of Georgia (“Blue Cross”) on behalf of its member physicians. The lawsuit contested Blue Cross’ refusal to share with contracted physicians the fee schedules and other information necessary to determine how much they would be paid for their services.

In ruling for the plaintiff physicians, the Georgia Court of Appeals stated:

We agree with the doctors that Blue Cross’ refusal to provide participating providers with a fee schedule and the precise methodology used to determine the usual, customary and reasonable fees for services is improper. A promise of future compensation must be for an exact amount or based upon a formula or method for determining the exact amount, and that amount or formula should be ascertainable from the contract. Here, the exact method used by Blue Cross for determining payment amounts is not ascertainable from the contracts or from the rules and regulations. Without such fee information, there is no way for doctors to calculate for themselves whether they have been fully paid for a particular service under the plan. While the doctors agreed to abide by Blue Cross’ rules and regulations, and while they agreed to allow Blue Cross to make changes to the reimbursement plan rules, the doctors never agreed to allow Blue Cross to keep its fee schedules and methods for determining fees secret. Such information

³ See, for example: Goodnough, A. (2015, February 16) Healthcare Success for Midwest Co-op Proves its Undoing. *The New York Times*. Retrieved from <http://www.nytimes.com>; see also Ramey, C. (2015, November 27) New York Health Co-Ops Collapses Hits Physicians. *The Wall Street Journal*. Retrieved from www.wsj.com.

⁴ See www.hmosettlements.com

is critical to the doctors so that they can ensure that Blue Cross is fulfilling its obligations under the contracts.

Medical Assn. of GA v. Blue Cross Blue Shield of Georgia, Inc., Ga. Ct. App. June 19, 2000.

The MDL litigation challenged several practices of the health insurers, including:

- “Gag clauses” in physician contracts designed to prohibit physicians from discussing certain treatment options, including expensive options or those not covered by patients’ plans.
- “All products” clauses requiring physicians to participate in all of an insurer’s products, including future products and government programs, such as Medicare and Medicaid, that often have significantly lower payment rates and more restrictive coverage policies. These clauses allow the insurer to coerce physician participation where the terms of the additional products are inadequate or unacceptable to the physician.
- Contracts allowing the health insurers to unilaterally change material terms, including payment amounts, without notice or consent of physicians.
- Medical necessity and utilization clauses allowing health insurers to require lower cost treatment options without regard to patients’ particular medical conditions.
- Failure to provide physicians with fee schedules and payment rules.
- Automatic “down-coding” of Evaluation and Management⁵ codes from the code appropriate for the service(s) the physician actually provided to the patient to a code for less complex service(s) that require less of the physician’s time and expertise. Down-coding results in significantly lower payment for the less complex service.
- Improper “bundling” of distinct services provided to patients with other services, resulting in no payments for the bundled service.
- Delayed payments for services rendered by physicians. These payment delays often violated state prompt payment statutes.

After several years of discovery, the defendant insurers agreed to historic legal settlements that imposed wide-ranging fair business practices and included approximately \$560 million in damages to the plaintiff physician class. One of the settlement agreements provided funding for the establishment of PAI to advocate for the fair payment policies adopted in all the settlements. The settlement agreements reached with Aetna, Humana, Anthem, Cigna, and other insurers included the following provisions:

⁵ Evaluation and management (“E&M”) codes are CPT® codes, commonly used to bill health insurers for physician-patient encounters. There are different E&M codes for different types of physician-patient encounters. However, there are generally five different levels of E&M codes based on the severity of a patient’s condition and/or the amount of time that the physician spends with a patient. Automatic “down-coding” of E&M codes resulted in lower payments to physicians.

- A prohibition on gag clauses;
- Adoption of a medical necessity definition allowing for cheaper treatment alternatives than those recommended by physicians only when the cheaper alternatives were “at least as likely to produce equivalent therapeutic or diagnostic results”;
- A prohibition on most all products clauses;
- A requirement to provide 90 days’ advance written notice of material adverse changes to physician contracts and the opportunity for physicians to terminate contracts prior to the effective date of the change;
- A requirement that the health insurers provide physicians with their fee schedules and payment edits and provide physicians with advance written notice of any changes to fee schedules;
- Compliance with specific coding rules, such as payment for procedures performed on the same date as an evaluation and management service appended with a 25 modifier⁶, and prohibitions on automatic down-coding of E&M codes; and
- Limitations on the timeframe in which the health insurers could seek recovery of alleged overpayments.

The total value of these business changes was estimated at two billion dollars.⁷

The settlement agreements were also significant because most of the provisions applied not only to the settling companies’ fully insured business, but also to Administrative Services Only (“ASO”) products administered by the insurers for self-insured plans. This was very important because insurers generally take the position that state laws governing insurance, such as prompt payment laws, are pre-empted by ERISA and therefore do not apply to self-insured plans.

The settlement agreements established a compliance process that allowed physicians and signatory medical societies to bring compliance disputes to enforce the terms of the settlement agreements. Upon receipt of a complaint, a compliance dispute facilitator appointed by Class Counsel made the initial determination as to whether an insurer violated the terms of the settlement and attempted to resolve the issue informally. If that was not successful, the dispute was submitted to a compliance dispute officer appointed by the MDL Court for mediation and/or a decision. PAI oversaw the compliance process through its Physician Advocacy Liaison Committee, comprised of legal counsel representing several of the PAI state medical societies and counsel for the Medical Society of the State of New Jersey.

Physicians and signatory medical societies faced innumerable challenges enforcing the settlements through the Court ordered compliance process. Some of the settling health insurers failed to implement the policy changes necessary to abide by the terms of the agreements. Two

⁶ Modifier 25 is used when a physician performs a separately identifiable E&M service on the same day of another procedure or other service.

⁷ This amount is based on the estimated total value of the business changes as set forth in §7.31 of most of the settlement agreements and in ¶2A of the Capital Blue Cross Settlement Agreement.

examples underscore the challenge faced by the physician and medical societies enforcing the settlements:

- Cigna settled in 2004 but has failed to pay approximately \$100 million, plus interest, in damages to many of the physicians who submitted claims for past underpayment and non-payment of claims under a special compensation fund established under the Cigna settlement agreement.
- As a result of compliance disputes brought by several medical societies alleging that Aetna's physician contracts violated key settlement agreement terms, including the prohibition on gag and all products clauses, Aetna agreed to issue addendums to physician contracts and extend the term of the settlement agreement by a year.

During the four years the settlement agreements were in effect, several hundred compliance disputes were filed against the health insurers, resulting in payments or savings to physicians of approximately 25 million dollars.⁸ Compliance disputes involved a myriad of issues, including:

- Requirements that physicians participate in Medicare Advantage plans in order to participate in an insurer's commercial plans in violation of the all products provision;
- Failure to comply with the settlements' coding rules, thereby reducing payments to physicians on such services as CAD mammography, myocardial perfusion, and pediatric developmental screening;
- Use of blended E&M rates to effectively "down-code" E&M codes;
- Failure to provide the settlement mandated 90 days' advance written notice before implementing material adverse changes to physician contracts;
- Failure to provide physicians with required 90 days' advance notice of reductions in fee schedule payments;
- Fee schedule amounts paid for vaccines impermissibly set at levels below physicians' costs to acquire and administer vaccines;
- Inclusion of language on patients' Explanation of Benefits forms that incorrectly advised patients that no payment was due to out-of-network physicians for their services;
- Use of global surgery periods longer than CMS', thereby depriving physicians of payment for certain services in conjunction with ancillary surgical procedures; and
- Use of longer than permitted look-back periods in claims recoupment.

⁸ The vast majority of this amount related to compliance disputes involving recoupment of alleged overpayment amounts beyond the timeframes allowed by the settlement agreement. This is an example of a provision that applied to both self-funded and fully insured claims, whereas state laws governing recoupment of alleged overpayment amounts are generally construed as applying only to fully insured plans.

III. HEALTH INSURER MARKET PRACTICES AFTER TERMINATION OF THE SETTLEMENTS

All of the MDL settlement agreements have now terminated.⁹ Unfortunately, no longer bound by the terms of the settlement agreements, health insurers have reverted back to utilizing some of the same unfair business practices that were the subject of the MDL litigation.

For instance, some of the settling health insurers are including mandatory waivers of class arbitrations in contracts, effectively denying legal recourse as a practical matter to combat abusive practices by health plans. Insurers are also once again bundling procedures with evaluation and management codes in a manner prohibited by the settlement agreements' coding provisions, thereby denying payment to physicians for certain services. Because state laws governing overpayment recovery are often considered as not applicable to self-funded and other ERISA plans, many insurers are seeking to recoup overpayments to physicians many years after such payments were initially made and unfairly subjecting physicians to audits years after claims were initially filed. All products clauses, largely prohibited by the settlement agreements, are now common provisions in physician contracts with health insurers. These clauses once again allow health insurers to add future products to physician contracts without providing physicians the opportunity to consent or decline participation in these products. Anthem commonly uses all products clauses in their contracts to require physicians to participate in less favorable plans such as plans on the health insurance exchange.

Specific examples from Tennessee and Texas illustrate how the emboldened insurers have expanded the types of unfair business practices to the detriment of physicians. In Texas, Aetna utilizes "one-way" all products clauses (as of 2004) and Humana's contracts (as of 2010) contain provisions that permit fee schedule "cherry-picking."

Aetna's contracts provide the following: Physician agrees to participate in the Plans and other health benefit products as described in the Product Participation Schedule. Company reserves the right, upon ninety (90) days prior notice, to introduce, modify and designate Physician's participation in Plans, Specialty Programs and products during the term of this agreement... Nothing in this Agreement shall require that Company identify, designate, or include Physician as a preferred participant in any specific Plan [.]

Similarly troubling language appears in Humana's contracts:

In the event Humana has access to Physician's, or a Participating Provider's, services through one or more other agreements or arrangements in addition to this Agreement, Humana will determine under which agreement or arrangement payment for Covered Services will be made.¹⁰

⁹ At the conclusion of the settlement agreements, some of the health insurers, including Aetna, agreed to voluntarily maintain some of the settlement terms in effect. Although some of the business changes required by the settlement agreements endure, such as providing physicians with fee schedules, others do not. More importantly, subsequent to the filing of the MDL litigation, the health insurers implemented new policies and payment models that harm physicians and their patients, such as tiered and narrow networks.

¹⁰ Available at <http://www.sec.gov/Archives/edgar/data/1429664/000119312511194811/dex1019.htm>

PAI urges the DOJ to consider the control these two provisions from the Aetna and Humana contracts would provide to a combined company. Through the Aetna agreement, any or all of the Humana products could be made part of the Aetna agreement, while granting the combined entity the ability to choose the most favorable payment rate for the combined company.

In Tennessee, Cigna employs several unfair contractual provisions to the detriment of participating physicians. Of particular concern is the Cigna contract's lack of payment transparency. The Tennessee Cigna contract is replete with vague provisions that give Cigna undue discretion over payment, even after a medical service is delivered. For instance, Cigna prohibits physicians from charging a patient for a service that is not "Medically Necessary." However, "Medical Necessity" is defined in Exhibit A to the Cigna contract as services that "satisfy the Medical Necessity requirements under the applicable Benefit Plan." Of course, physicians generally do not have access to their patients' benefit plan provisions. This leaves physicians guessing whether they will be paid.

The Tennessee Cigna agreement also gives Cigna the right to steer beneficiaries to select (generally lower cost) "in network" physicians to the detriment of other contracted physicians. This is counter-intuitive to any reasonable business agreement. Physicians generally enter into networks for the purpose of securing a volume of referrals in exchange for a discounted rate. This contract provision allows Cigna to actually steer patients *away* from the contracted physician.

IV. PAI OPPOSITION TO THE PROPOSED MERGERS

A. General Concerns With Erosion of Health Insurance Competition

Insurers benefit from consolidation because with more market power comes greater leverage over pricing (with regard to both the cost of insurance products and the amount spent on provider services) and increased ability to impose conditions on insurance policies and physician contracts that affect patient choice and access to care. Consumers who lack choice in health care coverage can pay not only financially, but also with their health.

Expert economists have determined that it takes a minimum of six competitors in the health insurance market to ensure optimal competitive conditions.¹¹ In considering physicians' experience with the MDL litigation in the context of analyzing the current proposed acquisitions, it is important to recognize that physicians and medical societies were compelled to litigate for fair insurer business practices when there were several large for profit health insurers in the country. Approving the proposed acquisitions would reduce that number to three, further condensing an already highly concentrated health insurance market and giving these three remaining "mega-insurers" power to dictate patient and physician contract terms and set market conditions. Such market power would make it very challenging for regulators to exercise oversight authority in areas such as network adequacy and fair business practices, as these behemoth entities would have power to threaten exiting the marketplace, leaving massive holes in coverage, should they find the regulatory climate unfavorable.

¹¹ Dafny L. "Competition in Health Insurance Markets" 2010, *American Economic Review*: Dranove, D., Gron, A. and M. Maseo, 2003, "Differentiation and Competition in HMA Markets" *Journal of Industrial Economics*

This level of market power tends to perpetuate itself by stifling new entrants from participating in the marketplace. Health insurers with significant market power often engage in aggressive contracting practices aimed at locking up the market for health care services and cutting out any would-be competitors. This type of anticompetitive behavior ensures continued market dominance, cementing the ability of the large insurers' to control costs, both as sellers of health insurance products and buyers of health care services. The AMA discussed the enduring nature of this level of market consolidation and PAI shares this concern.

The AMA, using the Herfindahl-Hirschman Index and the DOJ Horizontal Merger Guidelines, has determined that the proposed Anthem-Cigna merger would likely enhance market power in the commercial (combined HMO, PPO, and PPS) markets in *ten* of the fourteen states in which Anthem is licensed to provide commercial insurance (CO, CT, GA, IN, KY, ME, MO, NH, NV, and VA).¹² The AMA has further determined that the Anthem-Cigna merger raises significant competitive concerns warranting scrutiny in the other four Anthem states (CA, NY, OH and WI).

The proposed Aetna-Humana merger would combine the two largest insurers of Medicare Advantage plans to form the largest Medicare Advantage insurer in the country, thus highly concentrating the Medicare Advantage market. The merger would also concentrate the Medicaid HMO market in several states.

In addition to its effect on local markets for commercial and government plans, the proposed mergers will likely cause a substantial reduction in competition for the ASO business of large national employers with employees in several states. For example, for employers headquartered in Anthem's service areas, its proposed merger with Cigna would eliminate one of Anthem's major competitors for this national business, in some cases leaving the resulting Anthem entity as essentially the only choice for ASO business. This erosion of competition would be exacerbated further if the Aetna-Humana merger were approved.

With respect to Anthem's proposed merger with Cigna, the Antitrust Division's analysis of the resulting market concentration should also take into consideration the fact that Anthem is a member of the Blue Cross and Blue Shield Association ("BCBSA"), and, as such, must abide by the restrictions in the BCBSA's licensing agreements. There are three restrictions that could impact the proposed Anthem-Cigna merger. First, Anthem cannot compete as a Blue Plan in any state where it does not own a license to do business as a Blue Plan. Second, Anthem cannot earn more than 20% of its revenue in any state in which it is a Blue licensee from non-Blue brand business. Third, at least two-thirds of Anthem's annual revenue (or two-thirds of its enrollment, excluding Medicare and Medicaid) must be attributable to services offered under the Blue marks.¹³

These licensing rules mean that for Anthem to operate Cigna as an Anthem plan in a state where it does not have a Blue license, it must use the Blue Card Program¹⁴ and add to the

¹² September 8, 2015 AMA press release: "AMA Releases Analyses on Potential Anthem-Cigna and Aetna-Humana mergers."

¹³ For a thorough analysis of the impact of the BCBSA licensing agreements on the proposed merger and its implication on market concentration, PAI would refer the Antitrust Division to the August 13, 2015 letter from the lead counsel in *In re Blue Cross Blue Shield Antitrust Litigation*, MDL No. 2406, No. 13-cv-20000 (N.D. Ala.), a copy of which is attached.

¹⁴ The Blue Card Program is a program of the BCBSA that allows members of BCBS plans anywhere in the country to be treated outside that Plan's licensed territory. The program adversely affects providers

concentration of the local Blue Plan in that state. To the extent Anthem instead decides to operate the former Cigna under a non-Blue brand (as it has done with its Unicare subsidiary), it must be mindful of the one-third total revenue limit. If it would exceed that revenue limit, it may cede some or all of the Cigna business to the Blue that currently owns the license in that state. As a result, in addition to eliminating Cigna as a major competitor to Anthem in many states and thereby increasing Anthem's market power, the proposed mergers would add to the market power of many non-Anthem Blues and the entire Blues' enterprise.

B. Likely Anticompetitive Market Conduct by Insurers as Purchasers of Health Care Services

It is worth exploring the specific types of anticompetitive market conduct health insurers are likely to undertake as both *buyers* of health care services and *sellers* of health insurance products.

Further concentration of the health insurance market would give these larger insurers monopsony-level buying power in many additional geographic markets. This would allow the insurers an even greater opportunity to dictate contractual terms detrimental to physicians and their patients, impose low reimbursement rates, and further restrict provider networks, hindering patient access and disrupting physician-patient relationships. The backtracking on the fair contracting requirements embodied in the MDL settlement agreements shines a light on what can be expected should these insurers gain even more market power through this proposed consolidation.

Since the advent of managed care in the U.S. health care marketplace, physicians and other health care providers have contracted with health insurers as a source for their patients. Put simply, physicians agree to accept discounted payments from health insurers as a quid pro quo for the payer "steering" patients to their medical practices. Steerage occurs when the insurers list contracted or "in network" physicians in their provider directories and encourage patients to choose them by applying lower deductibles, co-pays, and co-insurance for services performed by in-network providers. Contracted physicians agree not to "balance bill" patients for their full billed charges. Conversely, patients who secure treatment from non-contracted or "out-of-network" providers generally face much higher deductibles, co-pays, and co-insurance, and may be billed for the balance of a provider's charges not paid by their benefit plans.

In markets where there are numerous competing health insurers, a physician who is offered an opportunity to contract with a specific insurer can assess several factors in order to determine if a contractual relationship is a good business decision. Key considerations include the benefits of gaining access to the insurer's patient base, the payment rates and other contract terms offered by the insurer, as well as coverage and administrative policies that would impact the physician's ability to provide high quality medical care to patients covered by the insurer. A common practice of many insurers is to present physicians with "take it or leave it" contracts. Physicians have little to no power or leverage to negotiate the payment and contractual terms of these agreements. Physicians are presented with contracts that they must sign as presented. Although many of these contracts contain a clause indicating that the contract was duly

because it gives every Blue Plan in whose territory treatment is sought the benefit of lower reimbursement rates paid to providers in that state, while at the same time ensuring that the Blue Plan that issued the policy controls the payment, utilization and benefit rules, which may not be accessible to the treating provider.

negotiated between the parties, the reality is that health insurers have the power in the market to dictate the terms of these contracts and do not allow negotiations of the key contractual terms.

Although a physician may not be able to actively negotiate over specific terms and conditions of a contract, he or she retains the option of walking away from the relationship. This is the physician's only leverage in what is an inherently uneven bargaining relationship with insurers. Absent competition in the health insurance market, insurers have even more leverage to dictate unfavorable contract terms and lower fee schedule amounts because physicians need to be in their networks to attract sufficient patients to sustain their practices.

PAI is concerned that the highly concentrated insurer markets resulting from the proposed mergers would create the classic monopsony situation in many markets, further exacerbating this already lopsided negotiating relationship. Many physicians in markets where the insurer has monopsony power would face a lose-lose scenario in which they either enter into an unfavorable non-negotiable contract with the insurer or remain non-contracted, which can make it impossible for the physician's practice to stay afloat.

Insurers that can wield unchecked pricing power in the physician market can force physician practices out of business in two ways: by unilaterally reducing contract prices to below the actual cost to produce services, or by simply excluding the physician from the plan network. With the increasing prevalence of narrow network plans, the latter threat has grown. When plans control large market shares, physicians can face the sudden loss of a large portion of their revenues, threatening the viability of the business. When markets are less concentrated, physicians can replace the lost business, but in highly concentrated markets, the practice may become permanently unprofitable and close.

Unfortunately, as the Department of Justice has recognized, physicians cannot readily re-locate to another geographic market where the health insurance market is less concentrated:

[F]or an established physician who has invested time and expense in building a practice, the costs associated with moving his or her practice to a new geographic market are considerable, including paying for new office space and equipment and building new relationships with hospitals, other physicians, employees and patients in the area.¹⁵

When insurers reduce payment and engage in unfair contracting practices, patients ultimately suffer. Patients are unable to find adequate in-network care and forced to pay greater out of pocket costs to seek out of network care. Lower reimbursement rates are likely to increase the already existing pressure on physicians to see more patients in a day, spending less time with each patient, defer making capital investments in their practices, retire early, and seek employment by hospitals or health systems rather than sustain independent practices. Physicians will be hard pressed to invest in infrastructures needed to maintain their current practice, develop the necessary infrastructure to participate in new incentive-based payment programs or meet federal standards such as electronic health records. Each of these trends can have a negative impact on patient access to high quality patient care and will in the long term exacerbate the physician shortage facing the nation.

¹⁵ *US v. Aetna Inc.*, Complaint No. 3-99CV 1398-H, ¶20 (June 21, 1999).

C. Likely Impact on Insurance Costs and Access

In addition to the enhanced insurer power on the “buying” side of the equation, there is little in the way of positive news for consumers should these mergers be approved. The insurers requesting approval claim that the mergers will result in lower health insurance premiums based on savings from innovative delivery models and incentive based payment. However, experience would strongly suggest that any savings reaped by lower reimbursement rates and narrow network designs will not translate into lower premiums. In fact, previous health insurer mergers have shown that to the contrary, premiums are likely to rise with consolidation.¹⁶

In PAI’s view, the alleged “efficiencies” and “economies of scale” promoted by the insurers in their efforts to seek approval are illusory. These insurers are all enormous, entrenched companies with significant resources and well-established positions in many of the markets in which they offer products. PAI believes that competition drives marketplace innovation. Companies are spurred to innovate when faced with competitors who are also vying to attract customers shopping for a high quality, low cost product. The health insurance marketplace is no different than any other market in that regard. However, in the health care marketplace the stakes for consumers are exceedingly high, and extremely personal, when competition fails.

Greater market power is also likely to even further accelerate insurers’ use of restrictive network configurations, including “narrow” and “tiered” products, to reduce costs at the expense of patient access to their choice of physicians and other health care providers. Narrow networks are precisely what the phrase connotes: restricted provider panels available for beneficiaries at “in network” rates. Insurers typically aim to exclude those providers deemed to be too expensive. These narrow network products can deprive patients of the full value of their benefit plan by de facto limiting access to certain providers and/or services. Unfortunately, state network adequacy regulation has not been effective in ensuring that marketed health plan products offer networks sufficient to provide patients ready access to covered health care services.

Narrow network products are problematic for several reasons, including the following:

- Narrow networks can disrupt physician-patient relationships when a patient’s physician is not included.
- Patients with narrow network products often bear much higher costs because they are forced to seek out-of-network treatment when they cannot locate or access an in-network physician specialist who performs the particular service needed for their medical care. Even for patients with out-of-network benefits, out-of-network care increases their costs -- often significantly -- because they face higher co-pays, co-insurance, and deductibles and can be “balanced billed” by health care providers. Patients without out-of-network benefits may be forced to bear the burden of their full cost of care.

¹⁶ See, the AMA’s November 11, 2015 letter to the Honorable William Baer, at pp. 2-3 and the testimony of Leemore Dafny, Ph.D. before the Senate Committee on the Judiciary cited therein: “If past is prologue, insurance consolidation will tend to lead to lower payments to health providers, but those lower payments will not be passed onto consumers. On the contrary, consumers can expect higher insurance premiums.”

- Because the Affordable Care Act prohibits insurers from overtly excluding patients with preexisting conditions, insurers can instead utilize narrow networks to strategically exclude physicians who treat patients with expensive medical conditions or who perform highly specialized medical procedures.
- Although a health plan may point to statistics showing sufficient numbers of a particular physician specialty in its network, those statistics may hide the dearth of available sub-specialists. For example, although a health plan network may have sufficient dermatologists in its network in a particular geographic location, it may have few, if any, dermatologists who perform Mohs surgery. Narrow networks may also include physicians who practice medicine part-time or whose practices are not open to new patients.
- Restrictive networks often force patients to travel significant distances to secure necessary medical care from an in-network specialist. In many cases, this precludes patients without access to ready transportation from accessing necessary medical care. This tends to particularly impact low-income and elderly patients.
- Narrow network designs pressure physicians to accept low reimbursement rates or suffer exclusion from the network.

The use of narrow networks has recently been of particular concern with Medicare Advantage and Exchange products. Although UnitedHealthcare (“United”) is not the subject of the Antitrust Division’s analysis in this instance, United currently has the largest share of the Medicare Advantage market, and therefore actions it has taken to narrow its Medicare Advantage network should be of great interest to the DOJ, particularly in analyzing the proposed Aetna-Humana merger. In late 2013, United sent tens of thousands of physicians throughout the country letters advising them that United was unilaterally amending their physician contracts to “discontinue” their participation in United’s Medicare Advantage network. Clearly, the quality of these physicians’ care was not an issue because the letter assured physicians that United was “pleased” to have them remain in its other networks.

Although United had claimed that it would continue to have sufficient physicians in its Medicare Advantage network, in a December 6, 2013 letter from the Centers for Medicaid and Medicare Services (“CMS”) to Connecticut Attorney General George Jepson, CMS admitted that it had not scrutinized the impact of United’s network terminations on various patient populations in Connecticut: “Our time/distance/number standards do not, however, take into account the special needs of the disabled, elderly, low income, without personal transportation, and non-English speaking members.”

Tiered networks are another mechanisms insurers use to contain costs. This type of plan encourages patients to seek treatment from physicians in the “top” tier through lower co-pays and/or deductibles. The health insurers use claims data to tier physicians. Although insurers often tout their use of quality measures to narrow or tier networks, the determination invariably includes a cost or “efficiency” component. Unfortunately, the standards used by the insurers to narrow or tier their networks are not usually transparent either to providers or to patients, and it can be difficult for providers to appeal their tier designations.¹⁷ Similarly, state network

¹⁷ This remains true despite an agreement reached by then New York Attorney General Andrew Cuomo with Aetna, Cigna, Empire Blue Cross Blue Shield (an Anthem company), UnitedHealthcare and other

adequacy oversight likely fails to consider if the network is adequate in the tier of providers with the lowest cost-sharing for patients. This is problematic as a patient may not be able to access a needed specialist or sub-specialist included in an insurer-designated tier with prohibitively high cost sharing.

V. CONCLUSION

The gravity of the decision before the DOJ and its lasting impact on the nation's health care system cannot be overstated. For all of the reasons set forth in this letter, PAI opposes the proposed acquisition of Cigna by Anthem and the proposed acquisition of Humana by Aetna and would urge the Antitrust Division to use its authority to block the mergers. It should be abundantly clear from our comments that "big is not better," and drastically reducing the number of competitive health insurers will create a "too big to fail" scenario in the health insurance industry.

PAI appreciates the Antitrust Division's interest in analyzing the anticompetitive effects of the proposed mergers on competition in the health insurance market and on physicians and their patients. We would welcome the opportunity to meet with you further about these issues, either by conference call or in person, and to provide you any additional information that would be helpful in your analysis.

Sincerely,



Robert W. Seligson, MBA, MA
President, Physicians Advocacy Institute, Inc.
Executive Vice President/CEO, North Carolina Medical Association

Attachments

insurers requiring more transparency in the designation process and better opportunities for physicians to appeal their designations. PAI has long been interested in this issue. In 2007, it offered a program for physicians, "Understanding Episodes of Care," whose purpose was to assist physicians in understanding how the insurers use episodes of treatment groupers to rate physicians based on the costs of care.